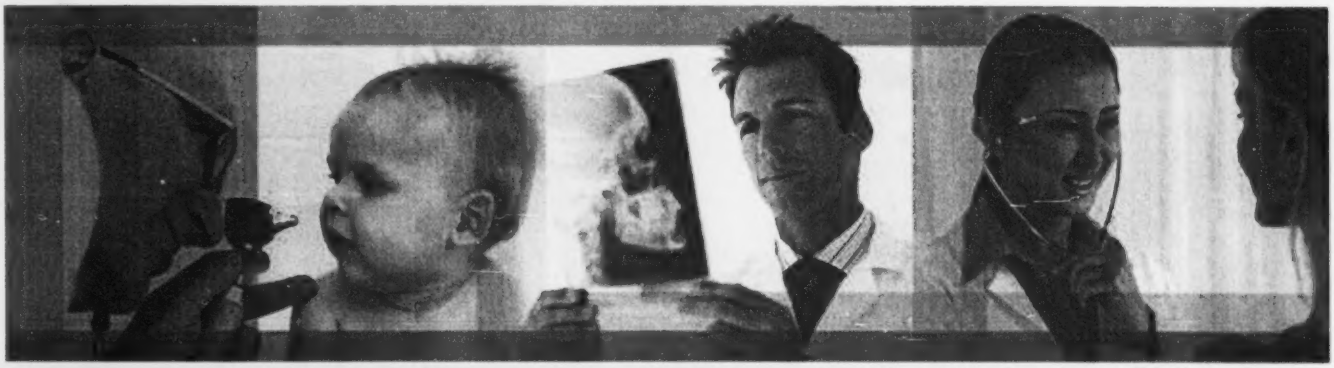
Physicians' Newsletter

PUBLISHED BY THE MEDICAL SERVICES PLAN FOR MEDICAL PRACTITIONERS *Winter 2009/10*



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Inserts Featured in this Newsletter:

- Complex Care Management Fee 2010 Update
- Medical Services Commission Payment Schedule Winter 2009

2010 Designated Statutory Holidays:

January 1	Friday	New Years Day	September 6	Monday	Labour Day
April 2	Friday	Good Friday	October 11	Monday	Thanksgiving Day
April 5	Monday	Easter Monday	November 11	Thursday	Remembrance Day
May 24	Monday	Victoria Day	December 27	Monday	In lieu of Christmas Day
July 1	Thursday	Canada Day	December 28	Tuesday	In lieu of Boxing Day
August 2	Monday	B.C. Day			

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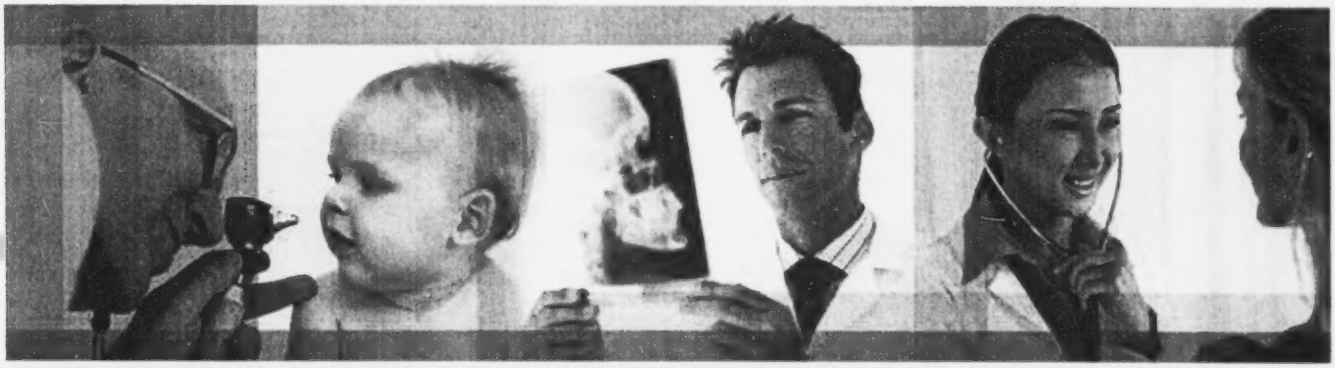

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Documentation Requirements for Pharmacist-Initiated Frequent Dispensing

The PharmaCare Frequency of Dispensing policy requires pharmacists to complete a Frequent Dispensing Authorization form when dispensing a 2-27 day supply that has not been ordered by the prescriber.

The form, signed by the patient, indicates why the patient needs frequent dispensing. Completed forms are faxed to the patient's primary health care practitioner.

- If the prescriber agrees with the frequency of dispensing, *no action is necessary.*
- *Please do not fax the form to PharmaCare or to the pharmacy. In this case, the form is for your information only.*
- If the prescriber does *not* agree with the dispensing frequency, we strongly encourage prescribers to fax the form back to the pharmacy and PharmaCare indicating their concern.
- By faxing the form to both PharmaCare and the pharmacy, PharmaCare can ensure that the patient's medication is dispensed as directed by the physician through its audit process.

Calling to check MSP coverage?

If you are calling to check your patient's MSP coverage, please contact Practitioner Services by calling 604 669-6667 in Vancouver or 1 800 742-6165 for all other areas of the province.

If your patient wishes to call for coverage information, please ask them to call 604 683-7151 in Vancouver or 1 800 663-7100 for all other areas of the province.

Enquiries to Practitioner Services are restricted to physician's offices.

Please share this information with your Medical Office Assistant.

2010 Close-Off Dates:					
January 6	March 4	May 5	July 6	September 3	November 3
January 20	March 22	May 19	July 21	September 21	November 19
February 4	April 6	June 4	August 4	October 5	December 6
February 17	April 21	June 21	August 20	October 20	December 20

Coverage for Out of Province and Out of Country Medical Services

The Ministry of Health Services (MoHS) provides coverage for hospital and physician services in Canada. Provincial coverage is available for out of country medical services, but the coverage is very limited.

The Medical Services Commission (MSC) is responsible for directing the level of coverage available for out of country services. Coverage details and the application process are outlined in the Out of Country Medical Care Guidelines for Funding Approval. The Guidelines are available on the MoHS website at the following link:

⇨ www.health.gov.bc.ca/msp/infoben/leavingbc.html#outofp

Provincial Coverage for Medical Services in Canada:
The Provinces (except Quebec) provide portable coverage for medical services in Canada; however, there are some medical services excluded from the Interprovincial Reciprocal Payment Agreement. For further information, please refer to the list of exclusions on page 13 of the Guidelines.

Provincial Coverage for Out-of-Country Medical Services:
B.C. coverage for emergency out of country medical services is limited to the provincial fee schedule rates for physician services and a $75.00 daily per diem for all in-patient hospital services.

B.C. coverage for elective out of country medical services must be pre-approved to ensure provincial health care funding is not provided for out of country medical services, when appropriate, acceptable and cost effective medical services are available in Canada.

It is important to note the terms 'emergency' and 'elective' refer to the provincial coverage, rather than the urgency for medical care. Emergency coverage applies when a B.C. resident is travelling and unexpectedly requires medical treatment. Elective coverage applies when a B.C. resident travels to obtain out of country medical services.

If the attending specialist wishes to request provincial coverage for an elective out of country medical treatment, the specialist must complete the Out of Country Medical Services Funding Application (the Application). The information on the Application will confirm the out of country treatment is medically necessary and the appropriate standard of care is not available for the beneficiary anywhere in Canada. If the out of country medical service is within the responsibility of a provincial program such as the B.C. Cancer Agency (oncology services) or the St. Paul's Eating Disorders Program (eating disorders), the Application must include a written recommendation from the provincial program director supporting the medical necessity for the out of country medical services.

The Guidelines and the Application are available on the MoHS website:

⇨ www.health.gov.bc.ca/msp/infoprac/oocc.html

If you require additional information regarding out-of -country coverage, or need assistance with the application, please contact the Out of Country Coordinator at Health Insurance B.C. at 250 405-3758 (phone) or 250 405-3588 (fax)

General Practice Services Committee (GPSC)
Full Service Family Practice Incentive Program

In order to improve the health outcomes of people living with Chronic Obstructive Pulmonary Disease (COPD), effective September 15, 2009, B.C. full service family practice physicians are eligible to receive an annual $125 bonus payment (G14053) for developing a COPD care plan in partnership with the patient and providing their COPD care in accordance with the B.C. COPD clinical guidelines recommendations. Guidelines can be found at:
⇨ www.bcguidelines.ca

Approximately 92,000 British Columbians are living with COPD and about 11,000 new cases are diagnosed each year. In 2007/08, COPD was the top diagnosis for patients admitted to B.C. hospitals and accounted for over 7,500 emergency department admissions.

This bonus payment may be billed with a date of service from September 15, 2009 onward.

Additionally, once the COPD CDM incentive (G14053) has been successfully billed, family physicians can access up to four telephone/email follow-up management fees (G14073) for these patients over the following 12 months.

The program payments recognize the value of optimal COPD management on patient health outcomes and the additional work, beyond the office visit payments, that is required to provide guideline based care to patients over a year.

A high number of COPD patients are receiving care in emergency departments when exacerbations Occur. It is hoped that this added investment to family physicians will result in fewer exacerbations and fewer emergency department and hospital visits for patients. GPSC will be reporting back to physicians the results of this initiative as data become available.

Eligibility:

The **Annual Chronic Care Bonus** is available to all general practitioners who have a valid B.C. Medical Service Plan practitioner number (registered specialty 00), except those who have billed any specialty consultation fee in the previous 12 months, and:

- Whose majority professional activity is in full service family practice as described in the introduction; and
- Who have provided the patient the majority of their longitudinal general practice care over the preceding year; and
- Have provided the requisite level of guideline-based care.

G14053 - Incentive for Full Service General Practitioner - annual chronic care bonus (Chronic Obstructive Pulmonary Disease COPD) $125.00

Notes:

i) General Practitioners who have a valid MSP practitioner number (registered specialty 00) are eligible to bill. Physicians who have billed a specialty consultation fee within the preceding 12 months are not eligible.

ii) Payable to the general practice full service family physician who has provided the majority of the patient's longitudinal general practice care over the preceding year and who has provided the requisite level of guideline-based care.

iii) Applicable only for patients with confirmed diagnosis of COPD.

iv) Care provided must be consistent with the B.C. clinical guideline recommendations for COPD and may only be billed after one year of care has been provided and the patient has been seen at least twice in the preceding 12 months. ***The patient must be given a copy of their personalized COPD care plan.***

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General Practice Services Committee (GPSC)
Full Service Family Practice Incentive Program

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- *v) Claim must include the ICD-9 code for chronic bronchitis (491), emphysema (492) bronchiectasis (494) or chronic airways obstruction-not elsewhere classified (496).*
- *vi) This item may only be claimed once per patient in a consecutive 12 month period.*
- *vi) Payable when other CDM items G14050, G14051 or G14052 have been paid on the same patient.*
- *viii) If a visit is provided on the same date the bonus is billed; both services will be paid at the full fee.*

G14073 - COPD Telephone/ Email Management Fee $15.00

This fee is payable for two-way communication with eligible patients via telephone or email for the provision of clinical follow-up management of a patient's COPD by the GP who has billed and been paid for the GPSC Annual Chronic Care Bonus for COPD (G14053). This fee is not to be billed for simple appointment reminders or referral notification.

Notes:

- *i) Payable to a maximum of four times per patient in the 12 months following the successful billing of the GPSC Annual Chronic Care Bonus for COPD (G14053).*
- *ii) Not payable unless the GP/FP is eligible for and has been paid for the GPSC Annual Chronic Care Bonus for COPD (G14053).*
- *iii) Telephone/Email Management requires two-way communication between the patient and physician or medical office staff on a clinical level; it is not payable for simple notification of office or laboratory appointments or of referrals.*
- *iv) Payable only to the physician paid for the GPSC Annual Chronic Care Bonus for COPD (G14053) unless that physician has agreed to share care with another delegated physician.*
- *v) G14016, Community Patient Conferencing Fee, payable on same day for same patient if all criteria met. Time spent on telephone with patient under this fee does not count toward the time requirement for G14016;*
- *vi) Not payable on the same calendar day as a visit or service fee by same physician for same patient with the exception of G14016.*
- *vii) Chart entry must record the name of the person who communicated with the patient or patient's medical representative, as well as capture the elements of care discussed.*

For more information please visit:

⇨ www.primaryhealthcarebc.ca/phc/gpsc_incentive.html

Audit Reports

Sections of the MSP Resource Manual mentioned in a number of the following reports are available on the Ministry of Health Services website at:

⇨ www.health.gov.bc.ca/msp/infoprac/physbilling/s6-billing.pdf

Dr. A. – General Practice

A general practitioner came to the attention of the Billing Integrity Program as a result of a routine review of practitioner billing profiles. A review of the practitioner's billing profile revealed that total services and costs per patient were considerably higher than the group average, and could not be explained by subsequent case-mix analysis which adjusts costs for patient age, gender and morbidity. Furthermore, the physician's use of self-referred electrocardiograms was more than five standard deviations above the peer group average and billings for proctosigmoidoscopies (with major tray services) were more than nine standard deviations above the peer group average for general practitioners.

A peer medical inspector found a number of instances where there was a lack of documentation in the medical records to justify the service billed. There were also a number of billings for prolonged counselling visits that should have been billed as regular office visits. A number of the self-referred electrocardiograms were found to be not medically required and therefore were disallowed. The major audit finding was the extraordinarily large number of billings under fee item FI-10714 (proctosigmoidoscopy, rigid) that had been inappropriately billed. The physician had failed to follow the definition in the Medical Services Commission (MSC) Payment Schedule relating to proctosigmoidoscopy and had billed FI-10714, plus a major tray service, when only a 4.25-inch proctoscope, and not a sigmoidoscope, had been utilized.

It was also observed that the physician had a predilection to use diagnostic coding for generalized signs and symptoms rather than the diagnostic coding appropriate to the patient's actual clinical condition. It is likely that the case-mix adjusted profile statistics would have been improved in the physician's favour had the appropriate diagnostic coding been noted on the Medical Services Plan (MSP) billings.

As a result of a negotiated settlement, the physician agreed to repay the MSC $100,000.00 inclusive of surcharge, interest and audit costs. Furthermore, the physician agreed to abide by a pattern of practice order in which adequate medical records will be maintained and claims will be submitted in accordance with the MSC Payment Schedule. It was further ordered that diagnostic tests be undertaken only when medically required, taking into consideration MSC clinical practice guidelines.

Dr. B. – General Practice

A general practitioner came to the attention of the Billing Integrity Program as the result of an unusual pattern of nursing home visits that had been detected. Further investigation, including an on-site inspection of records, revealed that there were missing or inadequate medical records for a large number of nursing home visits and the medical requirement for these services was not substantiated. There were also a large number of office-based billings where the medical records were inadequate and did not provide sufficient information to support the fee items billed, the frequency of service, or the medical requirement of the service itself.

As a result of a negotiated settlement, the practitioner agreed to repay the MSC $100,000.00 inclusive of costs, interest and surcharge, and to abide by a pattern of practice order in which adequate medical records will be maintained and claims will be submitted to MSP in accordance with the MSC Payment Schedule, with specific attention to Preamble Clauses A1, B.1.a, B.2 and B.4.e(vii) regarding nursing home visits and other insured services.

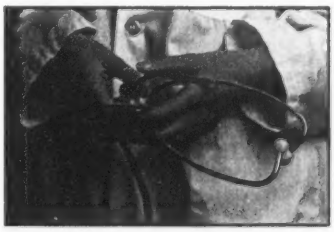
Dr. C - General Practice

A general practitioner came to the attention of the Billing Integrity Program as part of a province wide project, which flagged practices with an unusually high proportion of counselling or complete examinations, compared to routine office visits.

Following further investigation, including an on-site audit of the physician's office, a peer medical inspector concluded that a large number of MSP claims for prolonged counselling did not meet the requirements of Preamble clause B4.c of the MSC Payment Schedule. No other concerns were identified and the physician's quality of care was noted to be commendable.

The practitioner did not agree with the medical inspector's assessment that a majority of the prolonged counselling claims were inappropriately billed. However, as the result of a negotiated settlement, the practitioner agreed, without making any admission of liability, to pay the MSC the sum of $83,275.00 in repayment of medical services billed to the MSC, plus a surcharge and interest in the amount of $20,193.00 and audit costs in the amount of $3,532.00 for a total amount of $107,000.00

The practitioner also agreed to abide by a pattern of practice order in which adequate medical records will be maintained and claims will be submitted in accordance with the MSC Payment Schedule with specific attention to Preamble Clause B4.c regarding prolonged counselling visits and the MSP Billing Guidelines published in the MSP Resource Manual for Physicians.



Vitamin D Testing in Primary Care

Background: In addition to being required for bone metabolism, vitamin D has been recently linked to a wide variety of common diseases like cancer, diabetes, and cardiovascular disease. There have also been reports of a role for vitamin D in periodontal disease, depression, chronic pain, autoimmune diseases, Parkinson's disease, memory loss, and even influenza. One consequence of this new interest in vitamin D is that utilization of the vitamin D (25) laboratory test fee item (92460) is growing exponentially, with a 100 per cent increase in costs to MSP over 2007/08. There is currently no consensus on the role of vitamin D testing in primary care.

Physiology: There are two sources of vitamin D: vitamin D2 (ergocalciferol) derived from plants, and D3 (cholecalciferol) produced in the skin by the action of UV light on 7-dehydrocholesterol. Both forms of vitamin D are hydroxylated in the liver to 25-hydroxyvitamin D. This, the major circulating form of vitamin D, undergoes further hydroxylation in the kidney to the active metabolite 1,25-dihydroxyvitamin D (calcitriol). Calcitriol stimulates intestinal calcium absorption, decreases parathyroid hormone secretion, stimulates osteoclastic bone resorption, stimulates osteoblasts, decreases production of collagen type 1, influences muscle function, and stimulates cell differentiation and the immune system.

Supplementation: Good vitamin D levels are unlikely to be achieved through diet alone and sufficient exposure to sunlight is generally not achieved for adequate vitamin D production (depending on surface area exposed, skin color, season and latitude). There is concern that low vitamin D levels in older adults are contributing to bone loss and subsequent fractures, and there are several Canadian recommendations regarding appropriate vitamin D intake. There is consensus among them that a daily dietary or supplemental source of at least 200 IU is required, with an upper limit of 1000 IU in infants and 2,000 IU thereafter. There is, however, controversy with regard to appropriate dosage within the 200 to 2,000 IU range, continuity through the year, and source (food vs. supplements).

Vitamin D testing: Currently, the vast majority of vitamin D testing is done on asymptomatic people who are thought to be at risk for sub-optimal vitamin D levels. This testing includes, but is not limited to, the elderly, particularly in residential care, and those who are thought to receive inadequate sun exposure. Vitamin D testing is expensive ($93.63 per test) and Provincial volumes are increasing exponentially. As supplementation is safe it is reasonable to supplement asymptomatic at risk people without testing. *Routine testing of vitamin D levels is medically unnecessary prior to or after starting vitamin D supplementation.* Vitamin D testing should be limited to patients with: unexplained raised serum alkaline phosphatase or low calcium or phosphate, atypical osteoporosis, and advanced age with unexplained proximal limb pain. Specialist consultation could be considered for patients with unexplained bone pain, unusual fractures or other evidence suggesting metabolic bone disease.

Summary: Testing of vitamin D levels in asymptomatic people at risk for having low vitamin D levels is not usually required because testing carries a high cost burden while supplementation is safe and relatively inexpensive. Physicians, and other health providers, should note that MSP insured vitamin D testing is not intended for use as a diagnostic screening tool. Rather, MSP funds testing in cases where there is clinical suspicion of severe, symptomatic, vitamin D deficiency.

Out-Patient Diagnostic Requisition Forms

The British Columbia Medical Association (BCMA)/Medical Services Branch (MSB) Working Committee to Review Standard Out-Patient Requisition Forms is fully operational and addressing important issues. This committee reports to the BCMA Board of Directors and the Medical Services Commission (MSC).

The Mandate of the Committee is to review Standard Out-Patient Diagnostic Requisition Forms, facilitate physician compliance with the Guidelines and Protocols Advisory Committee, ensure appropriate test ordering and reduce potentially excessive utilization. The committee supports the implementation of the Guidelines and Protocols and assists in the creation of records for audit purposes.

According to the *Medicare Protection Act*, Section 5(1)(o), the process for requesting changes to standard outpatient requisition forms is as follows:

- The request should be made in writing.
- The request should outline the rationale for the requested change and any potential impact on utilization.
- The request should be submitted to the Secretary of the Working Committee on Standard Out-patient Requisition Forms.
- A representative of the group requesting a change to a Standard Requisition Form may be invited to make a presentation to the Requisition Committee.
- The BCMA Board of Directors will designate a representative from each diagnostic modality with whom the Committee must consult in respect to proposed changes to that diagnostic specialty's standard requisition.

All requests should be directed to the Secretariat of the BCMA/MSB Working Committee to Review Standard Out-Patient Requisition Forms:

Diagnostic Facilities Administration
Medical Services Branch
Ministry of Health Services
3-1, 1515 Blanshard Street
Victoria BC V8W 3C8
Greer.Olsen@gov.bc.ca
Fax: (250) 952-2507

Recommendations of the Committee will be forwarded to the BCMA Board of Directors and the MSC for approval, along with documentation on any dissenting diagnostic specialty views.

Standard Out-Patient Breast Imaging Requisition

On July 15, 2007, the Guidelines & Protocols Advisory Committee released an updated Mammography Guideline – Protocol for the Use of Diagnostic Facilities. As a result, the Standard Out-Patient Breast Imaging Requisition has been revised, and the following two "tick boxes" were added under the "Present Complaint" section of the requisition:

1. Unknown Primary Malignancy
2. First Post-Operative Mammography

The change of this standard requisition was effective May 14, 2009, the date the Breast Imaging Requisition was published.

STANDARD OUT-PATIENT
BREAST IMAGING REQUISITION

X-RAY FACILITY ADDRESS | X-RAY USE ONLY

BILLABLE TO:
☐ MSP ☐ ICBC ☐ WCB ☐ PATIENT ☐ OTHER:

NAME OF PHYSICIAN & MSP PRACTITIONER NUMBER (or office stamp)

PERSONAL HEALTH NUMBER | DOB: YYYY / MM / DD

SURNAME OF PATIENT | FIRST NAME AND MIDDLE INITIAL

TELEPHONE # (INCLUDE AREA CODE) | GENDER ☐M ☐F | PREGNANT ☐Yes ☐No

ADDRESS | CITY/TOWN | POSTAL CODE

COPY RESULTS TO:

☐ DIAGNOSTIC MAMMOGRAPHY ☐ ULTRASOUND

☐ Proceed to further imaging if indicated (mammography or ultrasound)
☐ Proceed to needle biopsy if indicated and feasible
OR
☐ Call me if further investigation is necessary

HISTORY

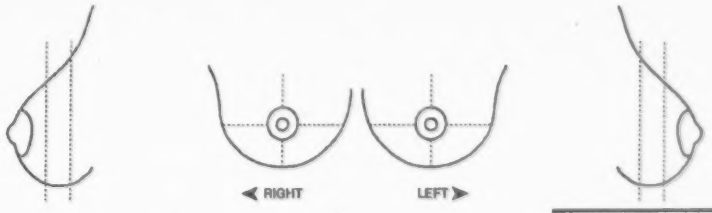
PREVIOUS MAMMOGRAMS ☐ YES ☐ NO	DATE(S):
PREVIOUS BIOPSIES / SURGERY ☐ YES ☐ NO	DATE(S):
HORMONE THERAPY ☐ YES ☐ NO	DATE(S):
FAMILY HISTORY OF BREAST CANCER ☐ YES ☐ NO	RELATIONSHIP
MENSTRUAL HISTORY LMP (DATE):	MENOPAUSE (AGE):

PRESENT COMPLAINT (Please check the appropriate indication)

☐ LUMP ☐ THICKENING ☐ LOCALIZED PAIN/TENDERNESS ☐ NIPPLE DISCHARGE
☐ "ABNORMAL" SCREENING MAMMOGRAM ☐ FOLLOW UP OF PREVIOUS FINDINGS ☐ PREVIOUS BREAST CANCER ☐ BREAST PROSTHESES (IMPLANTS)
☐ UNKNOWN PRIMARY MALIGNANCY ☐ FIRST POST-OPERATIVE MAMMOGRAPHY

☐ OTHER, SPECIFY:

PLEASE MARK AREA(S) OF CONCERN WHEN APPROPRIATE



TELEPHONE REQUISITION TIME	INITIALS OF RECORDER	DATE SIGNED (YYYY / MM / DD)	SIGNATURE OF REQUESTING PHYSICIAN

HLTH 1908 2008/05/14

Government - British Columbia Medical Association Partnership
Benefiting Family Physicians and Patients across BC

The General Practice Services Committee (GPSC), established in 2004 with the input of 1,000 B.C. general practitioners (GPs), has allocated $125 million annually for six years for programs for physicians.

Primary care renewal in British Columbia – long identified as key to health system sustainability – was given a significant boost seven years ago with the creation of the GPSC.

The joint Ministry of Health Services-British Columbia Medical Association committee, charged with finding solutions for challenges faced by B.C.'s full service family physicians, developed a two-pronged strategy for allocating new, targeted funding from government: *financial incentives* and *practice support*. Priority areas, to be gradually addressed by both financial incentives and practice support, were set:

- Chronic disease management;
- Maternity care;
- Care of the frail elderly, and patients requiring end of life care;
- Patients with complex care needs;
- Prevention;
- Mental health;
- Recruitment and retention of full service family practitioners; and,
- Multidisciplinary care between general practitioners and health care providers.

The GPSC's 2009 annual report confirms the strategy has been a solid one, reaping benefits for patients, physicians and the health system overall.

Full Service Family Practice Incentive Program

Early GPSC incentive payments for physicians, under what became known as the Full Service Family Practice (FSFP) Incentive Program, included an annual condition-based payment for diabetes and congestive heart failure care, and an obstetrical premium fee. The incentives were well received by GPs and led to a significant expansion in the responsibilities of, and funding for, the GPSC in 2006.

FSFP highlights of the 2009 GPSC annual report include:

- *Chronic Disease Management (CDM):* Hundreds of thousands more B.C. patients with diabetes, congestive heart failure (CHF) and hypertension received evidence-based care last year thanks to an incentive payment for physicians who apply clinical guideline recommendations in treating these conditions. More than 3,000 GPs billed for the annual $125 (per patient) diabetes care payment, and nearly 2,000 for the $125 CHF payment. Almost 3,000 received the annual $50 payment-per-patient for managing hypertension according to guidelines. Just over $34 million was allocated for CDM incentive payments last year.
- *Mental Health:* Under a Community Mental Health Initiative, a mental health planning fee is available to GPs who develop a patient's mental health plan, including a comprehensive review of his/her history, an assessment of psychosocial symptoms, a clinical plan that includes linkages with other healthcare professionals, and communication of the plan to the patient and other professionals. Last year 1,829 GPs participated, developing a mental health plan for 49,697 patients (2008/09 total expenditure: $5,552,900).
- *Patients with Complex Care Needs:* GPs are eligible for $315 per patient/per year for developing and monitoring care plans for patients with two or more of: diabetes, end stage kidney disease, vascular disease and respiratory disease. Last year 2,550 GPs billed the fee, benefiting 108,145 patients. A $15 email/telephone follow up management fee, payable up to four times per year/per patient, was also instituted, enabling doctors to discuss clinical issues between visits with patients or their medical representative. GPs used this fee for follow-up with 6,582 patients last year.

Practice Support Program: Beyond Incentives

Although independent incentives are important, the UK experience has shown that incentives alone don't lead to full-system change. The GPSC developed the Practice Support Program (PSP) to maximize such change, providing family physicians and medical office assistants with practical, evidence-based strategies and tools to enhance their practices. The program, delivered regionally by practice support teams in each health authority, offers training modules on: chronic disease management, patient self-management, advanced access scheduling, group patient visits, and most recently, mental health care.

PSP highlights of the 2009 GPSC annual report include:

- As of March 31, 2009, more than 1,200 (about one third) of B.C.'s general practitioners, with their medical office assistants, have participated in PSP programs; $15.4 million of the $20 million one-time funding has been allocated to date.
- GPs who completed the advanced access module decreased the average wait time for regular appointments from 5.8 to 2.5 days.
- 89 per cent of GPs who completed the chronic disease management module said it enabled them to deliver better patient care.
- 93 per cent of GPs who completed the self-management module are now comfortable helping patients to adopt self-managed care.
- 91 per cent of GPs who completed the group medical visits module felt group visits increased patient satisfaction.

Building on Demonstrated Success

The GPSC launched new initiatives in 2009. An end of life planning fee and telephone/email management fee was implemented on June 1, 2009. This fee supports GPs to ensure the best quality of life for dying patients and their families. The PSP will also develop an end-of-life module to support clinical and practice change.

An acute care discharge planning conference fee was implemented on June 1, 2009 to enable community GP participation in discussions with hospital staff about the return of complex patients to the community or their transition to a different facility.

An initiative supporting multidisciplinary care practice is also slated for implementation in 2009/10.

For more information on the GPSC, visit: ⇨ www.bcma.org.

Applications for Psychiatric Medication Coverage

Applications for Psychiatric Medication Coverage (HLTH 3497) must be faxed **only** to a Mental Health Services Centre or the mental health contact at your health authority.

Please verify that the fax number for the centre is correct and provide your own fax number. If you inadvertently send the fax to a wrong number, providing your fax number will allow the recipient to contact you and advise you of the error.

Faxing to any other number compromises patient privacy and may result in coverage not being in place when needed.

The most recent version of the Application for Psychiatric Medication Coverage (HLTH 3497) is available at:

⇨ www.health.gov.bc.ca/exforms/mhdforms/3497fil.pdf

Surgery for Alteration of Appearance

Surgery to alleviate significant physical symptoms or to restore or improve functions to any area altered by disease, trauma, or congenital deformity is normally a Medical Service Plan (MSP) benefit. Surgery solely to alter or restore appearance is not an MSP benefit except under the circumstances indicated in the Medical Services Commission Payment Schedule Preamble.

Authorization is not required for all surgery to alter appearance. Authorization is required only for those categories of procedures for which some cases may not be an MSP benefit. Pre-authorization is also required to ensure that the most appropriate fee items are used. When pre-authorization has been granted, MSP may occasionally also require an operative report to support the claim in cases where different fee items may apply.

Authorization is given consideration after a formal written request is submitted by the **operative** surgeon, indicating symptoms of medical necessity and the proposed surgical fee item(s). If there is a change in the planned procedure, the surgeon should bill the appropriate fee item(s) with a note record or operative report. Authorization is generally valid for two years. If the surgery is not performed within two years, another authorization request must be submitted.

If authorization has been denied and you wish to have the decision reviewed, re-apply for authorization in the same manner and provide additional details to substantiate your request. Re-applications are reviewed independently by MSP's medical and surgical advisors.

If the services are pre-authorized through a **Letter of Authorization**, the authorization also gives the patient approval for coverage of hospital charges if the patient is admitted to an acute care hospital as an inpatient or daycare patient.

The application for pre-authorization is available on the MSP website at:

⟹ www.health.gov.bc.ca/exforms/mspprac/2769fil.pdf

The following fee items are checked for pre-authorization:

02130	02350	02351	02352	02353
02354	02355	02409	06109	06112
06113	06114	06115	06125	06126
06131	06150	06152	06155	06157
06164	06165	06178	08296	08363
61025	61026	61031	61050	61057
61152	61166	61167	00228	06179

PharmaCare Coverage Olanzapine and Ziprasidone

Ziprasidone is now a Limited Coverage drug, covered under the same PharmaCare plans as olanzapine (i.e., all PharmaCare plans including the No-Charge Psychiatric Medication Plan). PharmaCare automatically covers ziprasidone for patients who meet the existing criteria for olanzapine (and vice versa).
The coverage criteria for olanzapine (which has not changed) also applies to ziprasidone:

- Patient specific diagnosis identified as schizophrenia or other psychosis (not dementia related) PLUS
- Treatment failure or intolerance to another specified anti-psychotic agent.

The coverage period for both olanzapine and ziprasidone is indefinite.

Patients who meet the criteria are eligible for both olanzapine and ziprasidone. Physicians can prescribe either medication at any time without further PharmaCare approval. Existing Special Authority approvals for olanzapine have been automatically updated to include ziprasidone.

This new coverage provides increased access to treatment alternatives while limiting the administrative burden on physicians.

To request coverage, use the General Special Authority Request form (HLTH 5328) available at:
⟹ www.health.gov.bc.ca/exforms/pharmacare/5328fil.pdf.

The B.C. Provincial Academic Detailing Service

What's new?

The B.C. Provincial Academic Detailing (PAD) service was launched in March 2008 as a new educational method of providing objective, evidence-based drug information to physicians and other health care professionals.

Academic detailing is a form of continuing medical education in which health professionals, usually pharmacists, meet with physicians one-on-one at their offices to discuss selected drug therapy topics. The academic detailing sessions, which usually last 15-30 minutes, are arranged at a time that is convenient for the physician. Each therapeutic topic is accredited by the University of British Columbia's Division of Continuing Professional Development as meeting the accreditation criteria of the College of Family Physicians of Canada for up to 1.0 Mainpro-M1 credits.

The first two PAD topics were HPV Vaccine and Anticoagulation in Atrial Fibrillation. Both have been well received by participating physicians. The next topic will be "Antibiotics in Community Practice" with a focus on respiratory tract infections and urinary tract infections. Academic detailing sessions for the antibiotic topic will take place between November 2009 and April 2010.

Currently, the B.C. PAD service has academic detailing pharmacists in four health authorities – Fraser, Vancouver Island, Interior and Northern. Funding is provided to the health authorities by the Ministry of Health Services, Pharmaceutical Services Division.

For more information about the B.C. PAD service, or how to contact the academic detailing pharmacist in your health authority, please call 604-660-1978 or e-mail PAD@gov.bc.ca.

Complex Care Management Fee – 2010 Update

The General Practice Services Committee (GPSC) has revised the conditions that are eligible for the Complex Care Incentive, with the following changes effective January 1, 2010.

Asthma and Chronic Obstructive Pulmonary Disease have been incorporated in a single category of "Chronic Respiratory Conditions". This category has also been expanded to include other chronic respiratory diseases such as cystic fibrosis and restrictive conditions such as pulmonary fibrosis and fibrosing alveolitis.

Two new disease categories are added: Chronic Neurodegenerative Disorders and Chronic Liver Disease (with hepatic dysfunction).

The complex care management fee was developed to compensate general practitioners (GPs) for the management of complex patients who have chronic conditions from at least two of the eight categories listed below. There are also fees for up to four non-face-to-face encounters during the 18 months following the billing of the complex care management fee.

These items are ***payable only to the GP or practice group that accepts the role of being most responsible for the longitudinal, coordinated care of that patient. By billing this fee the GP or practice accepts that responsibility for the ensuing calendar year.***

The Most Responsible GP or practice group may bill these fees when providing care only to community patients; i.e. residing in their homes or in assisted living with two or more of the following chronic conditions:

1) ***Diabetes mellitus (type 1 and 2)***
2) ***Chronic renal failure with eGFR values less than 60***
3) ***Congestive heart failure***
4) ***Chronic respiratory condition (asthma, emphysema, chronic bronchitis, bronchiectasis, Pulmonary Fibrosis, Fibrosing Alveolitis, Cystic Fibrosis etc.)***
5) ***Cerebrovascular disease***
6) ***Ischemic heart disease, excluding the acute phase of myocardial infarct***
7) ***Chronic neurodegenerative diseases (multiple sclerosis, amyotrophic lateral sclerosis, parkinson's disease, alzheimer's disease, stroke or other brain injury with a permanent neurological deficit, paraplegia or quadriplegia etc.)***
8) ***Chronic liver disease with evidence of hepatic dysfunction***

Eligibility:

These payments are available to:

- All GPs who have a valid B.C. Medical Service Plan practitioner number (registered specialty 00), except those who have billed any specialty consultation fee in the previous 12 months; and
- Whose majority professional activity is in full service family practice as described in the introduction, and
- Who has provided the patient the majority of their longitudinal general practice care over the preceding year, and
- The GP or practice group that is most responsible for the ongoing care of the patient.

Restrictions:

- Not payable to physicians who have been paid for any specialty consultation fee in the previous 12 months.
- Not payable to physicians who are employed by, or who are under contract to, a facility whose duties would otherwise include provision of this care.
- Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.

The complex care management visit can be provided and billed once at anytime in the calendar year. The development of the care plan is done jointly with the patient and/or the patient's representative, as appropriate. ***The patient and/or their representative/family should leave the planning process knowing there is a plan for their care and what that plan is.***

If a patient has more than two of the qualifying conditions, when billing the complex care management fee the submitted diagnostic code from Table 1 (refer to page 5) should represent the two conditions creating the most complexity.

Successful billing of the complex care management fee (G14033) allows access to four telephone/email follow-up fees (G14039) over the following 18 months. Once the complex care plan is reviewed and revised in the subsequent calendar year, the allowable G14039 fees resets to four over the following 18 months.

The GPSC strongly recommends accurate ICD-9 diagnostic coding when billing for care of these patients throughout the year. ICD-9 diagnostic codes can be downloaded from the Ministry of Health Services website at: www.health.gov.bc.ca/msp/infoprac/diagcodes/index.html

G14033 – Annual Complex Care Management Fee **$315**

The complex care management fee is advance payment for the complexity of caring for patients with two of the eligible conditions and is payable upon the completion and documentation of the complex care plan for the management of the complex care patient during that calendar year.

A complex care plan requires documentation of the following elements in the patient's chart:

- there has been a detailed review of the case/chart and of current therapies;
- there has been a face-to-face visit with the patient, or the patient's medical representative if appropriate, on the same calendar day that the complex care management fee is billed;
- specifies a clinical plan for the care of that patient's chronic diseases covered by the complex care management fee;
- incorporates the patient's values and personal health goals in the complex care plan with respect to the chronic diseases covered by the complex care management fee;
- outlines expected outcomes as a result of this plan, including end-of-life issues when clinically appropriate;
- outlines linkages with other health care professionals that would be involved in the care and their expected roles;
- identifies an appropriate time frame for re-evaluation of the complex care plan; and
- confirms that the complex care plan has been communicated verbally or in writing to the patient and/or the patient's medical representative, and to other involved health professionals as indicated.

The development of the complex care plan is done jointly with the patient and/or the patient representative, as appropriate. ***The patient and/or their representative/family should leave the planning process knowing there is a plan for their care and what that plan is.***

Notes:

i) Payable once per calendar year.

ii) Payable in addition to office visits or home visits same day.

iii) Visit or CPx fee to indicate face-to-face interaction with patient same day must accompany billing.

iv) G14016, community patient conferencing fee, payable on same day for same patient if all criteria met.

vi) G14015, facility patient conferencing fee, not payable on the same day for the same patient, as facility patients not eligible.

vii) G14017, acute care discharge planning conferencing fee, not payable on the same day for the same patient, as facility patients not eligible.

viii) CDM fees G14050/G14051/G14052/G14053 payable on same day for same patient, if all other criteria met.

ix) Minimum required time 30 minutes in addition to visit time same day.

x) Maximum of five complex care fees per day per physician.

xi) Not payable for patients seen in locations other than the office, home or assisted living residence where no professional staff on site.

Diagnostic codes submitted with 14033 billing must be from Table 1. If the patient has multiple co-morbidities, the submitted diagnostic code should represent the two conditions creating the most complexity of care.

G14039 – Complex Care Telephone/E-mail Follow-Up Management Fee $15.00

This fee is payable for follow-up management, via two-way telephone or e-mail communication, of patients for whom a complex care management fee (G14033) has been paid. Access to this fee is restricted to the GP that has been paid for the complex care management fee (G14033) within the preceding 18 months and is, therefore, Most Responsible GP (MRGP) for the care of that patient for the submitted chronic conditions. The only exception would be if the billing GP has the approval of the MRGP and this must be documented as a note entry accompanying the billing. As with all clinical services, dates of services under this item should be documented in the patient record together with the name of the person who communicated with the patient or patient's medical representative as well as a brief notation on the content of the communication.

Notes:

i) Payable a maximum of four times per patient in the 18 months following the successful billing of G14033.

ii) Not payable unless the GP/Family Practitioner (FP) is eligible for, and has been paid for, the annual complex care management fee (G14033) within the previous 18 months.

iii) Telephone or e-mail management requires two-way communication between the patient and physician or medical office staff on a clinical level; it is not billable for simple notification of office appointments.

iv) Payable only to the physician that has successfully billed for the annual complex care management fee (G14033) unless the billing physician has the approval of the GP responsible for the annual complex care management fee (G14033) and a note entry is submitted indicating this.

v) G14016, community conferencing fee, payable on same day for same patient if all criteria met. Time spent on telephone under this fee with patient does not count toward the time requirement for G14016.

vi) G14015, facility patient conferencing fee, not payable on the same day for the same patient as facility patients not eligible.

vii) G14017, acute care discharge planning conferencing fee, not payable on the same day for the same patient, as facility patients not eligible.

viii) Not payable on the same calendar day as a visit fee by the same physician for the same patient.

ix) Chart entry requires the capture of the name of the person who communicated with the patient or patient's representative as well as capture of the elements of care discussed.

How to Bill:

Have a face-to-face visit with the eligible patient, and/or the patient's medical representative if appropriate:

- Review the patient's history/chart and create a complex care plan including the elements itemized above, which is billable only on the day of a face-to-face visit;
- Over the rest of the calendar year, conduct a review of the complex care plan and provide other follow-ups as clinically indicated. Follow-up may be face-to-face or by telephone/e-mail as appropriate, with the appropriate fee being payable.

Step 1. Create a Complex Care Plan **G14033** **$315**

The complex care management fee acknowledges that eligible patients require medical management that is more time intense and complex. This fee compensates the GP/FP for the creation of a clinical action plan for the patient as described above, and for the additional complexity of managing these patients for the calendar year in which the complex care plan is billed. The initial service allowing access shall be the development of a complex care plan for a patient residing in their home or assisted living (excluding care facilities) with two or more chronic conditions from two different eligible categories. This requires fulfillment of the itemized elements of service and documentation of these as specified in the fee item above. Please refer to page six for the complex care plan template.

Diagnostic codes for the complex care management fee (G14033) must be one of the codes from Table 1. If the patient has multiple co-morbidities, the submitted diagnostic code should reflect the two conditions creating the most complexity of care.

Step 2. Provide Office Visit Follow-Up

Visits for the rest of the year are billable under the appropriate MSP fee and with the ICD-9 code of the presenting complaint. Table 1 diagnostic codes should not be used for follow-up services. Table 1 codes were created for billing only the complex care management fee (G14033).

Step 3. Provide Follow-Up Telephone/Email Management **G14039** **$15**

These fees allow medical management through two-way telephone or email communication with the patient and/or the patient's medical representative. These non-face-to-face services are payable to a maximum of four times in the 18 months following the successful billing of the 14033 fee. These services will also be applied toward the majority source of care calculation for these patients. As with the office visit follow-up, ICD-9 codes used in submitting the telephone/e-mail management fees should reflect the most appropriate condition requiring this service. Table 1 diagnostic codes should not be used. Table 1 codes were created for billing only the complex care management fee (G14033).

Step 4. Using the Diagnostic Codes Listed in Table 1

Many software programs in use in B.C. do not allow capture of more than one diagnostic code per billing. Diagnostic codes have therefore been developed to cover all combinations of any two of the chronic condition categories covered under the complex care fees. These codes are listed in Table 1 and should be used only when submitting the complex care management fee (G14033). All follow-up fees should use real ICD-9 codes. When a patient has co-morbidities from more than two categories, the submitted diagnostic code should reflect the two conditions creating the most complexity of care.

Table 1: Complex Care Diagnostic Codes

Diagnostic Code	Condition One	Condition Two
N519	Chronic Neurodegenerative Disorder	Chronic Respiratory Condition
N414	Chronic Neurodegenerative Disorder	Ischemic Heart Disease
N428	Chronic Neurodegenerative Disorder	Congestive Heart Failure
N250	Chronic Neurodegenerative Disorder	Diabetes
N430	Chronic Neurodegenerative Disorder	Cerebrovascular Disease
N585	Chronic Neurodegenerative Disorder	Chronic Kidney Disease (Renal Failure)
N573	Chronic Neurodegenerative Disorder	Chronic Liver Disease (Hepatic Failure)
R414	Chronic Respiratory Condition	Ischemic Heart Disease
R428	Chronic Respiratory Condition	Congestive Heart Failure
R250	Chronic Respiratory Condition	Diabetes
R430	Chronic Respiratory Condition	Cerebrovascular Disease
R585	Chronic Respiratory Condition	Chronic Kidney Disease (Renal Failure)
R573	Chronic Respiratory Condition	Chronic Liver Disease (Hepatic Failure)
I428	Ischemic Heart Disease	Congestive Heart Failure
I250	Ischemic Heart Disease	Diabetes
I430	Ischemic Heart Disease	Cerebrovascular Disease
I585	Ischemic Heart Disease	Chronic Kidney Disease (Renal Failure)
I573	Ischemic Heart Disease	Chronic Liver Disease (Hepatic Failure)
H250	Congestive Heart Failure	Diabetes
H430	Congestive Heart Failure	Cerebrovascular Disease
H585	Congestive Heart Failure	Chronic Kidney Disease (Renal Failure)
H573	Congestive Heart Failure	Chronic Liver Disease (Hepatic Failure)
D430	Diabetes	Cerebrovascular Disease
D585	Diabetes	Chronic Kidney Disease (Renal Failure)
D573	Diabetes	Chronic Liver Disease (Hepatic Failure)
C585	Cerebrovascular Disease	Chronic Kidney Disease (Renal Failure)
C573	Cerebrovascular Disease	Chronic Liver Disease (Hepatic Failure)
K573	Chronic Kidney Disease (Renal Failure)	Chronic Liver Disease (Hepatic Failure)

Complex Care Plan Template

Initial Planning Date: _____

Patient Name: _____

Condition #1: _____ **Condition #2:** _____

Diagnostic Code: _____

Patient Values/Goals: _____

_____

_____

Plan for Management of Co-Morbid Conditions:

_____

_____

_____

_____

_____

Linkage with other Heath Care Professionals:

_____

_____

_____

Discussed with AHP: _____

Expected Outcomes:

_____

_____

_____

Time frame for Re-Evaluation: _____

Discussed with: Patient _____ **Representative:** _____

_____

Re-Evaluation Date: _____

Change(s) to Plan, if any:

_____

_____

_____

Discussed with: Patient _____ **Representative:** _____ **AHP:** _____

Frequently Asked Questions:

1. **What is the purpose of the Complex Care Management Fees?**
   The complex care management fees have been created to provide recognition that patients with co-morbid conditions require more time and effort to provide quality care, and to remove the financial barrier to providing this care as opposed to seeing more patients of a simpler clinical condition.

2. **What is a Complex Care Plan?**
   The initial service allowing "portal" access to the complex care fees shall be the development of a complex care plan for a patient residing in their home or assisted living (excluding care facilities) with two or more of the above chronic conditions. This plan should be reviewed and revised as clinically indicated. It is essentially an expansion of the Subjective Objective Assessment Plan formula for chart documentation.

   A complex care plan requires documentation in the patient's chart that:
   - there has been a detailed review of the case/chart and of current therapies;
   - there has been a face-to-face visit with the patient or the patient's medical representative if appropriate, on the same calendar day that the complex care management fee is billed;
   - specifies a clinical plan for the care of that patient's chronic diseases covered by the complex care fee;
   - incorporates the patient's values and personal health goals in the care plan with respect to the chronic diseases covered by the complex care management fee;
   - outlines expected outcomes as a result of this plan, including end-of-life issues when clinically appropriate;
   - outlines linkages with other health care professionals that would be involved in the care and their expected roles;
   - identifies an appropriate time frame for re-evaluation of the plan; and
   - confirms that the care plan has been communicated verbally or in writing to the patient and/or the patient's medical representative and to other involved health professionals as indicated.

3. **What is the difference between "assisted living" and "care facilities"?**
   There are a wide range of living facilities currently available. Some, referred to under the terms of this initiative as 'assisted living' facilities, provide only basic supports such as meals and housecleaning, and do not provide their residents with nursing and other health support. A "care facility" on the other hand, is defined under the terms of this initiative as being a facility that does provide supervision and support from other health professionals such as nurses.

4. **Why is this incentive limited to patients living in their homes or assisted living?**
   While there may be exceptions, patients residing in a long-term care facility or hospital usually have a resident team of health care providers available to share in the organization and provision of care. Patients residing in their homes or in assisted living usually do not have such a team, so the organization and supervision of care is usually more complex and time consuming for the GP.

5. **Why are there restrictions excluding physicians "who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care" or to "physicians working under salary, service, or sessional arrangements?"**
The current fee-for-service payment schedule tends to encourage the provision of a higher volume of easier services as opposed to fewer, more complex and time-intensive services. This incentive has been designed to offset this disincentive.

   If a physician is already compensated for providing these services through terms of employment, or through time-neutral payments such as salary, service, or sessional arrangements, their time is considered to be already compensated.

6. **There are many co-morbidities that result in complexity of care. Why is this incentive limited to a list of eight categories of conditions?**
Compiling the list of eligible conditions has been difficult, and has required a careful balance. It is apparent that many additional conditions create complexities in providing care, but at the same time the GPSC is contractually required to remain within its budget.

   After feedback from the Full Service Family Practice GPs of B.C., effective January 1, 2010 the GPSC's revision of the complex care initiative has expanded the number of eligible patients. While asthma and COPD have been combined into a single "Chronic Respiratory Condition", this category has also been expanded to include other chronic respiratory diseases such as cystic fibrosis and restrictive airways diseases such as fibrosing alveolitis and pulmonary fibrosis. Also, the GPSC has added two new disease categories: chronic neurodegenerative disorders and chronic liver disease (with hepatic dysfunction). While there are other conditions that add to complexity, this expansion to eight categories covers a significant number of the medical co-morbidities that are seen in the population of B.C. This list will undergo ongoing review and potential modification in the future.

7. **Why did the GPSC create "fake" diagnostic codes for the Complex Care Management Fee?**
TelePlan requires software to be able to capture more than one diagnostic code, but many versions of software currently used do not support this. To get around this barrier without requiring that many GPs modify their current software, the GPSC created different diagnostic codes to indicate all combinations of two eligible criteria. These dual diagnostic codes have been revised this year to reflect the changes and additions to the categories. You will need to review and revise your patient diagnostic code to align with the revisions. Effective January 1, 2010 the new diagnostic codes for these patients must be utilized.

8. **What do I do if my patient has more than two of the eligible conditions?**
When billing the complex care management fee (14033) use the diagnostic code from Table 1 that indicates the two conditions causing the most complexity. All subsequent visits/services should use the ICD-9 code for the condition requiring the visit/service.

9. **Am I eligible to bill for the community patient conferencing fee (G14016) in addition to receiving the complex care management payment(s)?**
   Yes. If the physician needs to conference with allied health professions about the care plan and any changes, then the services provided in conferencing with other health care professionals is payable over and above the complex care management payments, provided that all criteria for the conferencing fee are met. The time spent on the phone or e-mail with the patient for the non-face-to-face complex care management does not count toward the total time billed under the community patient conferencing fee.

10. **What is the difference between the complex care telephone/e-mail follow-up management fee (G14039) and the community patient conferencing fee (G14016)?**
    The complex care follow-up telephone/e-mail management payment relates to services provided to the patient or the patient's medical representative as indicated. The community patient conferencing fee relates to services spent conferencing with other health care providers in a two-way discussion on the provision of care to benefit the patient.

11. **Am I eligible to bill for the chronic disease management fee(s) (G14050/G14051/G14052/G14053) in addition to receiving the complex care payment(s)?**
    Yes. The chronic disease management fees (G14050, G14051, G14052 and G14053) are independent of the complex care fees, and are payable on the same patient as long as the criteria for those fees are met.

12. **Why is the complex care telephone/e-mail follow-up management fee (G14039) restricted to the GP that has been paid for the annual complex care fee (G14033)?**
    This fee is designed to allow greater flexibility in providing follow-up to a plan that has been created. The GP that has been paid for the annual complex care management fee in the previous 18 months has also accepted the responsibility of being the MRGP for that patient's care for the two submitted chronic illnesses. The annual complex care management plan requires work, the shouldering of responsibility, and the co-ordination of care. It has considerable value. This fee is therefore restricted to the GP that has created the clinical action plan.

13. **If the complex care telephone/e-mail follow-up management fee is restricted to the GP who has been paid for the annual complex care management fee, what do group practices do when they share the care of the patient?**
    An exception has been made, allowing another GP to bill for this fee with the approval of the MRGP. This allows flexibility in situations when patient care is shared between GPs. In this circumstance, the alternate GP must submit the claim with a note record indicating he/she is in the group of the MRGP and is sharing the care of the patient.

    If a disagreement arises about the billing of this service, the GPSC will adjudicate based upon whether the MRGP (i.e the GP paid for the annual complex care fee) approved or did not approve the service provided. The GPSC feels that this provides the maximum flexibility while still maintaining responsibility.

14. Can I bill the follow-up management fees if I have billed for the annual complex care fee, but have not yet been paid?

Adjudication of this will depend upon whether the GP is eventually paid for the annual complex care fee. In other words, if a GP bills the annual complex care management fee (G14033) then provides, and bills for, a follow-up service under G14039 prior to receiving payment for G14033, payment for G14039 will be made only if G14033 is subsequently paid to that GP. Until that time it will show as "BH' on the remittance.

15. Are the payments eligible for the rural premiums?

No.

BRITISH COLUMBIA
The Best Place on Earth

UPDATE TO THE MEDICAL SERVICES COMMISSION PAYMENT SCHEDULE
WINTER 2009

PREAMBLE

Amendments:

Effective June 26, 2009, the following wording marked by strikethrough is deleted from Preamble B. 9. d.:

B. 9. Surgery

d. Operation Only

For listings designated "operation only" the pre-operative and post-operative visits may be claimed in addition to the surgical procedure, with the exception of the visit(s) made on the day of the procedure. ~~Surgical procedures that are equal to or less than $125.00 will be considered "operation only" procedures.~~

GENERAL SERVICES

Amendments:

Effective August 7, 2009, the provisional status ("P") of the following items is removed:

10010	DTaP-P (Diphtheria, Tetanus, Pertussis, Polio)	$4.07
10011	DTaP-P-Hib (Diphtheria, Tetanus, Pertussis, Polio, Haemophilus influenza type b)	$4.07
	Note: *Not payable with 10010 or 10018 on the same day, same patient.*	
10012	Td (Tetanus, Diphtheria)	$4.07
10013	TdP (Tetanus, Diphtheria, Polio)	$4.07
	Note*: Not payable with 10012 or 10019 on the same day, same patient.*	
10014	TdaP (Tetanus, Diphtheria, Pertussis)	$4.07
	Note: *Not payable with 10013 on the same day, same patient.*	
10015	Flu (Influenza)	$4.07
10016	HA (Hepatitis A)	$4.07
10017	HB (Hepatitis B)	$4.07
10018	HiB (Haemophilus influenza type b)	$4.07
	Note: *Not payable with 10011 on the same day, same patient.*	
10019	IPV (Polio Vaccine - Inactivated)	$4.07
	Note: *Not payable with 10010, 10011 or 10013 on the same day, same patient.*	
10020	MEN-C-C (Meningococcal-Conjugate-C)	$4.07
10021	MEN-C-ACYW135 (Meningococcal-Conjugate-ACYW135)	$4.07
10022	MMR (Measles, Mumps, Rubella)	$4.07
10023	PNEU-C-7 (Pneumococcal Conjugate C-7)	$4.07
10024	PNEU-P-23 (Pneumococcal-Polysaccharide-23)	$4.07
10025	RAB (Rabies)	$4.07
10026	VAR (Varicella)	$4.07

DIAGNOSTIC AND SELECTED THERAPEUTIC PROCEDURES

Amendments:

Effective June 1, 2009, the Provisional status ("P") of the following fee items is hereby removed:

S11960	Oximetry at rest, with or without Oxygen – professional fee
S11961	Oximetry at rest, with or without Oxygen – technical fee
S11962	Oximetry at rest and exercise, with or without Oxygen – professional fee
S11963	Oximetry at rest and exercise, with or without Oxygen – technical fee

GENERAL PRACTICE

GPSC Fees:

Pursuant to the 2006 Letter of Agreement, the Medical Services Commission supports access and improvement to full service family practice by recognizing the following fee items initiated by the General Practice Services Committee.

The following new listings are added, effective June 1, 2009:

GPSC Palliative Care Planning and Management Fees

The Palliative Care Incentive is a new payment initiative that is intended to complement the existing conferencing component of end-of-life care when sharing care with other health care professionals. To date, the GPSC has developed the community and facility patient conferencing fees which appropriately compensate the family physician for their role in conferencing with other team members in supporting the care needs for these patients.

Preparation and advance care planning are a critical first step once it has been determined that a patient's condition is terminal. With the GPSC Palliative Care Incentive payment, family physicians will be encouraged to take the time needed to work through the various decisions and plans that need to be determined to ensure the best possible quality of life for dying patients and their families. A new "Palliative Care Planning fee" will compensate the family physician for undertaking and documenting a care plan that will include the following components:

- A statement of the patient's primary medical diagnosis.
- A statement that the patient is medically palliative based on the physician's medical diagnosis AND the patient's agreement to no longer seek treatment aimed at cure.
- A list of the potential health care needs and the plan for managing these needs. As an example this may include Home and Community Care support services such as home support, home nursing care, personal care, after-hours palliative care, respite and/or hospice care; access to palliative medications, and supplies and equipment through the Provincial Palliative Benefits Program.
- A detailed, current plan for symptom management, including completing the application form and process to access the Palliative Benefits Program when appropriate.
- A list of the clinical indicators on when referral/access to specialist palliative care services may be needed.
- A copy of the patient's most current advance directive if available; and
- Completion and retention of forms to support a planned natural home death when this is part of the patient goal (Notification of a Planned Home Death; No CPR form, etc.).
- Physicians and patients are encouraged to ensure these documents will be available to the local emergency room in the event of patient attendance there.

In addition, once the planning process has been completed and the planning fee successfully billed, the Family Physician or practice group will be able to access up to five phone/e-mail follow-up management fees.

G14063 Palliative Care planning fee.....$100.00

This fee is payable upon the development and documentation of a Palliative Care Plan for patients who have been determined to have reached the palliative stage of a life-limiting disease or illness, with life expectancy of up to six months, and who consent to the focus of care being palliative rather than treatment aimed at cure. Medical Diagnoses include end-stage cardiac, respiratory, renal and liver disease, end stage dementia, degenerative neuromuscular disease, HIV/AIDS or malignancy. Eligible patients must be resident in the community; in a home or in assisted living or supportive housing. Facility-resident patients are not eligible for this initiative.

This fee requires the GP to conduct a comprehensive review of the patient's chart/history and assessment of the patient's current diagnosis to determine if the patient has a life-limiting condition that has become palliative and/or remains palliative. It requires a face-to-face visit and assessment of the patient. If the patient is incapable of participating in the assessment to confirm and agree to their being palliative, then the patient's alternate substitute decision maker or legal health representative must be consulted and asked to provide informed consent.

Notes:

i) Requires documentation of the patient's medical diagnosis, determination that the patient has become palliative, and patient's agreement to no longer seek treatment aimed at cure.

ii) Patient must be eligible for B.C. Palliative Care Benefits Program (not necessary to have applied for palliative care benefits program).

iii) Payable once per patient once patient deemed to be palliative. Under circumstances when the patient moves communities after the initial palliative care planning fee has been billed, it may be billed by the new GP who is assuming the ongoing palliative care for the patient.

iv) Payable in addition to a visit fee billed on the same day.

v) Minimum required time 30 minutes in addition to visit time same day.

vi) G14016, community patient conferencing fee payable on same day for same patient if all criteria met.

vii) Not payable on same day as G14015, facility patient conferencing fee.

viii) Not payable on same day as G14017, acute care discharge planning.

ix) Not payable on the same day as G14069 (Palliative Care Telephone/E-mail management fee).

x) G14050, G14051, G14052, G14053, G14033, G14034 not payable once Palliative Care Planning fee is billed as patient has moved from active management of chronic disease to palliative.

xi) G14043, G14044, G14045, G14046, G14047, G14048, G14049 the GPSC Mental Health Initiative Fees are payable once G14063 has been billed provided all requirements are met, but are not payable on same day.

G14069 Palliative Care Telephone/E-mail follow up management fee.....$15.00

This fee is payable for two-way communication with eligible patients via telephone or e-mail for the provision of clinical follow-up management by the GP who has created and billed for the Palliative Care Planning fee (G14063). This fee is not to be billed for simple appointment reminders or referral notification.

Notes:

i) Payable to a maximum of five times following successful billing of Palliative Care Planning fee G14063.

ii) Telephone/e-mail Management requires two-way communication between the patient and physician or medical staff on a clinical level; it is not payable for simple notification of office appointments.

iii) Payable only to the physician paid for the Palliative Care Planning fee (G14063) unless that physician has agreed to share care with another delegated physician.

iv) Not payable on the same day as a visit fee.
v) Not payable on the same day as G14063, Palliative care planning fee.
vi) G14016, Community Patient Conferencing Fee, payable on same day for same patient if all criteria met. Time spent on telephone under this fee with patient does not count toward the time requirement of G14016.
vii) Not payable on same day as any of G14043, G14044, G14045, G14046, G14047, G14048 or G14049, GPSC Mental Health Initiative fees.
viii) Not payable on same day as G14015, Facility Patient Conferencing Fee.
ix) Not payable on same day as G14017, Acute Care Discharge Planning Conferencing Fee.
x) Chart entry must record the name of the person who communicated with the patient or patient's medical representative, as well as capture the elements of care discussed.

Eligibility for G14063 and G14069
- Eligible patients are community-based (living in their home, with family or assisted living).
- Payable only to the GP or practice group that accepts the role of being most responsible for longitudinal coordinated care of the patient for that calendar year.
- Not payable to physicians who have been paid for any specialty consultation fee in the previous 12 months.
- Not payable to physicians who are employed by a health authority or agency or who are under contract whose duties would otherwise include the provision of this care.
- Not payable to physicians working under a salary, service contract or sessional arrangements and whose duties would otherwise include the provision of this care.

The following new listing is added, effective June 1, 2009:

G14017 General Practice Acute Care Discharge Conference fee
This fee is billable when a Discharge Planning Conference is performed upon the request of either an Acute Care facility, or by the GP accepting MRP status upon discharge, regarding a patient with complex supportive care needs, for review of condition(s) and planning for safe transition to the community or to a different facility; another acute care facility, or a supportive care or long-term care facility.
- per 15 minutes or greater portion thereof.....$40.00

Eligible Patient Population
- Frail elderly (ICD-9 code V15)
- Palliative care (ICD-9 code V58)
- End of life (ICD-9 code V58)
- Mental illness
- Patients of any age with multiple medical needs or complex co-morbidity

Eligible Physician Population
In order to improve continuity of patient care upon discharge from an acute care facility, this incentive payment is available to all GPs who:
- Have a valid B.C. Medical Service Plan practitioner number (registered specialty 00) (practitioners who have billed any specialty fee in the previous 12 months are not eligible); and
- Whose majority professional activity is in full service family practice as described in the introduction; and
- Is considered the most responsible GP for that patient following discharge from the acute care facility

Notes:
i) Refer to Table 1 for eligible populations.(refer to page 6)
ii) Payable only for patients being discharged from an acute care facility to the community or to a different facility; another acute care facility, or a supportive care or long-term care facility.
iii) Must be performed in the acute care facility and results of the conference

must be recorded in the patient's chart in the acute care facility and the receiving GP's office chart (or receiving facility's chart in the case of inter -facility transfer).

iv) *Face-to-face conferencing is required; the only exception is if a patient is being discharged from an acute care facility in a different community, and a chart notation must be made to indicate this circumstance.*

v) *Requesting care providers limited to: Facility-affiliated physicians and nurses, GP assuming MRP status upon patient's discharge, care coordinators, liaison nurses, rehab consultants, social workers, any healthcare provider charged with coordinating discharge and follow-up planning.*

vi) *Requires interdisciplinary team meeting of the GP assuming MRP status upon discharge and a minimum of two other health professionals as enumerated above, and will include family members when appropriate.*

vii) *Fee includes:*
   - a) *Where appropriate, interviewing of and conferencing with patient, family members, and other health providers of both the acute care facility and community.*
   - b) *Review and organization of appropriate clinical information.*
   - c) *The integration of relevant information into the formulation of an action plan for the clinical care of the patient upon discharge from the acute care facility, including provision of Degrees of Intervention and end-of-life documentation as appropriate.*
   - d) *The care plan must be recorded and must include patient identifiers, reason for the care plan, list of co-morbidities, safety risks, list of interventions, what referrals to be made, what follow-up has been arranged.*

viii) *This fee does not cover routine discharge planning from an acute-care facility, nor is this fee payable for conferencing with acute-care nurses during the course of a patient's stay in the acute care facility.*

ix) *Maximum payable per patient is 90 minutes per calendar year. Maximum payable on any one day is 60 minutes.*

x) *Claim must state start and end times of the service.*

xi) *If multiple patients are discussed, the billings shall be for consecutive, non-overlapping time periods.*

xii) *Not payable to physicians who are employed by or who are under contract to a facility who would otherwise have attended the conference as a requirement of their employment or contract with the facility; or physicians working under salary, service contract or sessional arrangements.*

xiii) *Medically required visits performed consecutive to the Acute Care Discharge Conference are payable.*

xiv) *Submit the new fee item G14017 through the MSP Claims System under the patient's PHN. The claim must include ICD-9 codes V15, V58, or the code for one of the major disorders.*

xv) *Not billable on the same day as Facility Patient or Community Patient Conferencing Fees (G14015 or G14016).*

xvi) *Not billable on the same day as any GPSC planning fees (G14033, G14043, G14063 (Palliative Planning Fee)).*

Table 1: Eligible patient populations for the Facility Patient, Community Patient and Acute Care Discharge Conference Fees.

i. Frail elderly (ICD-9 code V15)

Patient over the age of 65 years with at least three out of the following factors:

- Unintentional weight loss (10 lbs in the past year)
- General feeling of exhaustion
- Weakness (as measured by grip strength)
- Slow gait speed (decreased balance and motility)
- Low levels of physical activity (slowed performance and relative inactivity)
- Incontinence
- Cognitive impairment

ii. Palliative Care (ICD-9 code V58)

Patient of any age who:

- Are living at home ("Home" is defined as wherever the person is living, whether in their own; home, living with family or friends, or living in a supportive living residence or hospice); and
- Have been diagnosed with a life-threatening illness or condition; and
- Have a life expectancy of up to six months, and
- Consent to the focus of care being palliative rather than treatment aimed at cure.

iii. End of life (ICD-9 code V58)

Patients of any age:

- Who have been told by their physician that they have less than six months to live; or
- With terminal disease who wish to discuss end of life, hospice or palliative care

iv. Mental illness

Patients of any age with any of the following disorders are considered to have mental illness.

- Mood Disorders
- Anxiety and Somatoform Disorders
- Schizophrenia and other Psychotic Disorders
- Eating Disorders
- Substance Use Disorders
- Infant, Child and Adolescent Disorders
- Delirium, Dementia and Other Cognitive Disorders
- Sleep disorders
- Personality Disorders
- Developmentally Delayed, Fetal Alcohol Spectrum Disorders and Autism Spectrum Disorders
- Sexual Dysfunction
- Dissociative Disorders
- Mental Disorders due to a General Medical Condition
- Factitious Disorder

Definitions and the management of these mental disorders are defined in the Manual: Management of Mental Disorders, Canadian Edition, Volume One and Two, edited by Dr. Elliot Goldner, Mental Health Evaluation and Community Consultation Unit, University of British Columbia. Definitions for Delirium, Dementia and Other Cognitive Disorders; Developmental Disabilities; Dissociative Disorders; Mental Disorders due to a General Medical Condition and Factitious Disorder are found in the Diagnostic and Statistical Manual of Mental Disorders - DSM-IVR

v. Patients of any age with multiple medical needs or complex co-morbidity

Patient of any age with multiple medical conditions or co-morbidities (two or more distinct but potentially interacting problems) where care needs to be coordinated over a period of time between several health disciplines. On your claim form use the code for one of the major disorders.

The following new fee items are effective September 15, 2009:

G14053 Incentive for Full Service General Practitioner - annual chronic care bonus (Chronic Obstructive Pulmonary Disease-COPD)..... $125.00

Notes:

i) GPs who have a valid MSP practitioner number (registered specialty 00) are eligible to bill. Physicians who have billed a specialty consultation fee within the preceding 12 months are not eligible.

ii) Payable to the general practice full service family physician who has provided the majority of the patient's longitudinal general practice care over the preceding year and who has provided the requisite level of guideline-based care.

iii) Applicable only for patients with confirmed diagnosis of COPD.

iv) Care provided must be consistent with the B.C. clinical guideline recommendations for COPD and may only be billed after one year of care has been provided and the patient has been seen at least twice in the preceding 12 months. The patient must be given a copy of their personalized COPD care plan.

v) Claim must include the ICD-9 code for chronic bronchitis (491), emphysema (492), bronchiectasis (494) or chronic airways obstruction-not elsewhere classified (496).

vi) This item may only be claimed once per patient in a consecutive 12 month period.

vii) Payable when other CDM items G14050, G14051 or G14052 have been paid on the same patient.

viii) If a visit is provided on the same date the bonus is billed; both services will be paid at the full fee.

G14073 COPD Telephone/Email Management Fee.....$15.00

This fee is payable for two-way communication with eligible patients via telephone or email for the provision of clinical follow-up management of a patient's COPD by the GP who has billed and been paid for the GPSC Annual Chronic Care Bonus for COPD (G14053). This fee is not to be billed for simple appointment reminders or referral notification.

Notes:

i) Payable to a maximum of four times per patient in the 12 months following the successful billing of the GPSC Annual Chronic Care Bonus for COPD (G14053).

ii) Not payable unless the GP/FP is eligible for and has been paid for the GPSC Annual Chronic Care Bonus for COPD (G14053).

iii) Telephone/e-mail management requires two-way communication between the patient and physician or medical office staff on a clinical level; it is not payable for simple notification of office or laboratory appointments or of referrals.

iv) Payable only to the physician paid for the GPSC Annual Chronic Care Bonus for COPD (G14053) unless that physician has agreed to share care with another delegated physician.

v) G14016, Community Patient Conferencing Fee, payable on same day for same patient if all criteria met. Time spent on telephone with patient under this fee does not count toward the time requirement for the G14016.

vi) Not payable on the same calendar day as a visit or service fee by same physician for same patient with the exception of G14016.

vii) Chart entry must record the name of the person who communicated with the patient or patient's medical representative, as well as capture the elements of care discussed.

Effective June 1, 2009; Note i) appended to the indicated fee item is amended as follows:

G14034 Cardiovascular Risk Assessment

Notes:

i) The eligible population will be males or females between 18 and 69 years of age, inclusive.

Effective June 1, 2009; Note x) appended to the indicated fee item is amended as follows:

G14015 General Practice Facility Patient Conference: When requested by a facility to review ongoing management of the patient in that facility or to determine whether a patient in a facility with complex supportive care needs can safely return to the community or transition to a supportive care or long-term facility - per 15 minutes or greater portion thereof

Notes:

x) Not payable on the same day for the same patient as the Community Patient Conference Fee (G14016) or Acute Care Discharge Planning Conference fee (G14017).

Effective July 15, 2009, Note ii) d. 3. b. appended to the indicated fee item is amended as follows in bold:

G14016 General Practice Community Patient Conference Fee: Creation of a coordinated clinical action plan for the care of community-based patients with more complex needs. Payable only when coordination of care and two-way collaborative conferencing with other health care providers is required (e.g. specialists, psychologists or counsellors, long-term care case managers, home care or specialty care nurses, physiotherapists, occupational therapists, social workers, specialists in medicine or psychiatry) as well as with the patient and possibly family members (as required due to the severity of the patient's condition)
- per 15 minutes or greater portion thereof

Notes:

ii) Fee includes:

d. The care plan must be recorded in the chart and include the following information:

3. Diagnosis:

*b. **V58** (Palliative/End of Life Care)*

The following amendments are effective September 15, 2009:
Note iv) is amended and Note vii) is deleted. Therefore, Note viii) will become note vii):

G14050 Incentive for Full Service General Practitioner
- annual chronic care bonus (diabetes mellitus)..... $125.00

Notes:

i) GPs who have a valid MSP practitioner number (registered specialty 00) are eligible to bill. Physicians who have billed a specialty consultation fee within the preceding 12 months are not eligible.

ii) Payable to the general practice full service family physician who has provided the majority of the patient's longitudinal general practice care over the preceding year and who has provided an adequate level of guideline-based care.

iii) Applicable only for patients with confirmed diagnosis of diabetes mellitus.

iv) Care provided must be consistent with the BC clinical guideline recommendations for diabetes mellitus and may only be billed after two columns of the flow sheet have been completed and the patient has been seen at least twice in the preceding 12 months.

v) Claim must include the ICD-9 code for diabetes (250).

vi) This item may only be claimed once per patient in a consecutive 12 month period.

vii) If a visit is provided on the same date the bonus is billed; both services will be paid at the full fee.

G14051 Incentive for Full Service General Practitioner
- annual chronic care bonus (congestive heart failure)

Notes:

i) GPs who have a valid MSP practitioner number (registered specialty 00) are eligible to bill. Physicians who have billed a specialty consultation fee within the preceding 12 months are not eligible.

ii) Payable to the general practice full service family physician who has provided the majority of the patient's longitudinal general practice care over the preceding year and who has provided an adequate level of guideline- based care.

iii) Applicable only for patients with confirmed diagnosis of congestive heart failure.

iv) Care provided must be consistent with the B.C. clinical guideline recommendations for congestive heart failure and may be billed once the Goals Column, Initial Review (baseline) Column and subsequent column (visit intervals to be determined by physician) have been completed and the patient has been seen at least twice in the preceding 12 months.

v) Claim must include the ICD-9 code for congestive heart failure (4280).

vi) This item may only be claimed once per patient in a consecutive 12 month period.

vii) If a visit is provided on the same date the bonus is billed; both services will be paid at the full fee.

Note v) and viii) are amended:

G14052 Incentive for Full Service General Practitioner
- annual chronic care bonus (hypertension)

Notes:

i) GPs who have a valid MSP practitioner number (registered specialty 00) are eligible to bill. Physicians who have billed a specialty consultation fee within the preceding 12 months are not eligible.

ii) Payable to the general practice full service family physician who has provided the majority of the patient's longitudinal general practice care over the preceding year and who has provided an adequate level of guideline-based care.

iii) Applicable only for patients with confirmed diagnosis of hypertension who do not also have a diagnosis of diabetes mellitus and/or congestive heart failure.

iv) Care provided must be consistent with the B.C. clinical guideline recommendations for hypertension.

v) May only be billed after the patient has been provided guideline based care for one year and the patient has been seen at least twice in the preceding 12 months. The patient must be given a copy of their flow sheet.

vi) Claim must include the ICD-9 code for hypertension (401).

vii) This item may only be claimed once per patient in a consecutive 12 month period.

viii) Not payable if 14050 or 14051 claimed within the previous 12 months.

ix) If a visit is provided on the same date the bonus is billed; both services will be paid at the full fee.

Effective June 1, 2009, the following fee item description is amended as indicated and the Notes are amended as indicated in bold. The other notes remain the same:

G14039 Complex Care Telephone/Email Follow-up Management.....$15.00

This fee is payable for follow-up management, via two-way telephone or email communication, of patients for whom a Complex Care Management fee (G14033) has been paid. Access to this fee is restricted to the GP that has been paid for the Complex Care Management fee (G14033) within the preceding 18 months and is therefore Most Responsible GP (MRGP) for the care of that patient for the submitted chronic conditions. The only exception would be if the billing GP has the approval of the Most Responsible GP, and this must be documented as a note entry accompanying the billing. As with all clinical services, dates of service under this item should be documented in

the patient record together with the name of the person who communicated with the patient or patient's medical representative as well as a brief notation on the content of the communication.

Notes:

*i) **Payable to a maximum of four times within 18 months following the successful billing of G14033.***

*ii) **Not payable unless the GP/FP is eligible for and has been paid for the GP Annual Complex Care Management Fee (G14033) within the previous 18 months.***

Effective June 1, 2009, the following fee item description is amended as indicated in bold, effective June 1, 2009:

G14043 GP Mental Health Planning Fee.....$100.00

This fee is payable upon the development and documentation of a patient's Mental Health Plan for patients resident in the community (home or assisted living, excluding care facilities) with a confirmed Axis I diagnosis of sufficient severity and acuity to cause interference in activities of daily living and warrant the development of a management plan.

This fee requires the GP to conduct a comprehensive review of the patient's chart/history, assessment of the patient's current psychosocial symptoms/issues by means of psychiatric history, mental status examination, and use of appropriate validated assessment tools, with confirmation of diagnosis through DSM IV diagnostic criteria. **It requires a face-to-face visit with the patient and/or the patient's medical representative.**

From these activities (review, assessment, planning and documentation), a Mental Health Plan for that patient will be developed that documents in the patient's chart, the following:

1. That there has been a detailed review of the patient's chart/history and current therapies;
2. The patient's mental health status and provisional diagnosis by means of psychiatric history and mental state examination;
3. The use of and results of validated assessment tools. The GPSC strongly recommends that these evaluative tools, as clinically indicated, be kept in the patient's chart for immediate accessibility for subsequent review. Assessment tools such as the following are recommended, but other assessment tools that allow risk monitoring and progress of treatment are acceptable:
   a) PHQ9, Beck Inventory, Ham-D for depression;
   b) MMSE for cognitive impairment;
   c) MDQ for bipolar illness;
   d) GAD-7 for anxiety;
   e) Suicide Risk Assessment;
   f) Audit (Alcohol Use Disorders Identification Test) for Alcohol Misuse;
4. DSM-IV Axis I confirmatory diagnostic criteria;
5. A summary of the condition and a specific plan for that patient's care;
6. An outline of expected outcomes;
7. Outlined linkages with other health care professionals (Including Community Mental Health Resources and Psychiatrists, as indicated and/or available) who will be involved in the patient's care, and their expected roles;
8. An appropriate time frame for re-evaluation of the Mental Health Plan;
9. That the developed plan has been communicated verbally or in writing to the patient and/or the patient's Medical Representative, and to other health professionals as indicated.

Effective June 1, 2009, the following fee item Notes are amended as indicated in bold. The other notes remain the same:

G14049 GP Mental Health Telephone/Email Management Fee.....$15.00

This fee is payable for two-way communication with eligible patients via telephone or email for the provision of clinical follow-up management by the GP who has created and billed for the GP Mental Health Planning Fee (G14043). This fee is not to be billed for simple appointment reminders or referral notification.

Notes:

i) Payable to a maximum of five times within 18 months following the successful billing of G14043.

ii) Not payable unless the GP/FP is eligible for and has been paid for the GP Mental Health Planning Fee (G14043) within the previous 18 months.

General Practice Preamble:

Effective May 1, 2009, the following is added to the General Practice Preamble:

General Practice Group Clinical Visit

The General Practice (GP) Group Clinical Visit should be billed under in-office visit fee items (12100, 00100, P15300, 16100, 17100, 18100) and billed for each patient seen in the session. The GP Group Clinical Visit is not appropriate for advice relating to a single patient. It applies only when all members of the group are receiving medically required treatment (i.e. each member of the group is a patient) and a direct individual medical interaction is made with each patient.

When a patient attends a group visit, it should be noted in their chart. A separate file should be maintained which documents all participants in each group visit.

The GP Group Clinical Visits are not intended for activities related to attempting to persuade a patient to alter diet or other lifestyle behavioural patterns other than in the context of the individual medical condition.

Not payable to physicians working under salary, service contract or sessional arrangements, and whose duties would otherwise include provision of this care.

For GP Group Clinical Prenatal Visits, billing should be under fee item 14091.

When billing for group clinical visits, provide start and end times of the service in the time fields.

Effective April 1, 2009, a heading in Note ii) is changed from "Total Daily Value" to "Daily Ranges":

Note: Daily Volume Payment Rules **Applying to Designated Office Codes**

(ii) The total of all billings under the codes listed in i) that are accepted for payment by MSP will be calculated for each practitioner for each calendar day. When such a daily total exceeds 50 the practitioner's payment on these codes for that day will be discounted. Moreover, when a daily total exceeds 65, a further payment discount will be made.

Daily Ranges *(for an individual practitioner for any single calendar day)*	**Discount Rate**	**Payment Rate**
0 to 50	0%	100%
51 to 65	50%	50%
66 and greater	100%	0%

General Practice Fee Amendments:

Effective June 26, 2009, the provisional status (P prefix) of the following fee item is rescinded:

14105 Management of labour and transfer to higher level of care facility for delivery

Effective May 1, 2009, the headings, fee item descriptions and notes are modified as indicated:
The heading "Hospital Visits" is replaced with the heading "GP Facility Visits".
GP Facility Visit Fees
Please read the entire facility listings as some visits are restricted to community based GPs with active or associate/courtesy hospital privileges.

00109 Acute care hospital admission visit $78.32

Notes:

i) This item applies when a patient is admitted to an acute care hospital for medical care rendered by a GP with active hospital privileges. It is not applicable when a patient has been admitted for surgery or for "continuing care" by a certified specialist.

ii) This item is intended to apply in lieu of fee item 00108, 13008 or 13108 on the first in-patient day, for that patient.

iii) Fee item 00109 is not applicable if fee item 12101, 00101, P15301, 16101, 17101, 18101, 12201, 13201, P15201, 16201, 17201, or 18201 has been billed by the same physician within the week preceding the patient's admission.

iv) Essential non-emergent additional visits to a hospitalized patient by the attending or replacement physician during one day are to be billed under fee item 00108 or 13008. The claim must include the time of each visit and a statement of need included in a note record.

v) For weekday daytime emergency visit, see fee item 00112. Fee items 12200, 13200, P15200, 16200, 17200, 18200 may be billed for additional evening, night time or weekend emergent hospital visits same day, same patient when the attending physician or replacement physician is specially called back as the patient's condition has changed, requiring the physician's attendance or due to a condition unrelated to the hospitalization. If physician is on-site and called for emergent care, fee items 00113, 00105 or 00123 are billable. The claim must include the time of service and an explanation for the visit included in the note record.

00108 Hospital visit..... $31.31

Notes:

i) Billable by GPs with active hospital privileges for daily attendance on the patients they have most responsibility for.

ii) Essential non-emergent additional visits to a hospitalized patient by the attending or replacement physician during one day are to be billed under fee item 00108 or 13008. The claim must include the time of each visit and a statement of need included in a note record.

iii) For weekday, daytime emergency visit, see fee item 00112. Fee items 12200, 13200, P15200, 16200, 17200, 18200 may be billed for additional evening, night time or weekend emergent hospital visits same day, same patient when the attending physician or replacement physician is specially called back as the patient's condition has changed, requiring the physician's attendance or due to a condition unrelated to the hospitalization. If physician is on-site and called for emergent care, fee items 00113, 00105 or 00123 are billable. The claim must include the time of service and an explanation for the visit included in the note record.

00128 Supportive care hospital visit.....$26.51

Notes:

i) Referring physician may charge one supportive care hospital visit for each day hospitalized during the first ten days of hospitalization and thereafter one visit for every seven days hospitalized {Preamble B.4.e.v)}.

ii) Essential non-emergent additional visits to a hospitalized patient by the attending or replacement physician during one day are to be billed under fee item 00108 or 13008. The claim must include the time of each visit and a statement of need included in a note record.

iii) For weekday, daytime emergency visit, see fee item 00112. Fee items 12200, 13200, P15200, 16200, 17200, 18200 may be billed for additional evening, night time or weekend emergent hospital visits same day, same patient when the attending physician or replacement physician is specially called back as the patient's condition has changed, requiring the physician's attendance or due to a condition unrelated to the hospitalization. If physician is on-site and called for emergent care, fee items 00113, 00105 or 00123 are billable. The claim must include the time of service and an explanation for the visit included in the note record.

T12148 Sub-acute hospital visit.....$39.87

Notes:

i) Payable only when provided to patients who have had an acute medical or surgical episode and have been transferred for sub-acute care. This may include sub-acute care in rehabilitation and convalescent care units where indicated.

ii) Payable two times per patient per week to a maximum of 90 days. In higher acuity situations, a note record explaining the medical necessity is required if additional visits are necessary.

iii) Not payable with 00108, 13108, 00128, 13128, 00127, 13127, 13148, 00112, 00109, 00114, 13114, or 00115.

iv) Essential non-emergent additional visits to a patient receiving emergent care by the attending or replacement physician during one day are to be payable under fee item 12148. The claim must include the time of each visit and statement of need included in a note record.

v) For weekday daytime emergency visit, see fee item 00112. Fee items 12200, 13200, P15200, 16200, 17200, 18200 are payable for additional evening, night time or weekend emergency visits same day, same patient when the attending physician or replacement physician is specially called back, out of office hours, due to a change in the patient's condition which requires the physician's attendance or due to a condition unrelated to the hospitalization. If physician is on-site and called for emergent care, fee items 00113, 00105 or 00123 are billable. The claim must include the time of service and an explanation for the visit included in the note record.

00127 Terminal care facility visit $39.87

Notes:

i) This item is applicable to the visits for palliative care rendered to terminally ill patients suffering from malignant disease or AIDS or end-stage respiratory, cardiac, liver and renal disease and end-stage dementia with life expectancy of up to 6 months and the focus of care is palliative rather than treatment aimed at cure. Billings for this item will only apply where there is no aggressive treatment of the underlying disease process and care is directed to maintaining the comfort of the patient until death occurs.

ii) This item may be billed for necessary visits rendered for a period not to exceed 180 days prior to death and is applicable to patients in an acute care hospital, nursing home or terminal care facility, whether or not the patient is in a palliative care unit. Under extenuating circumstances, for visits that exceed 180 days, a note record must be submitted.

iii) Terminal care visit fees do not apply when unexpected death occurs after prolonged hospitalization for another diagnosis unrelated to the cause of death.

iv) *The chemotherapy listings (33581, 33582, 33583, P00578, P00579, and P00580) may not be billed when terminal care facility visit fees are being billed.*

v) *Essential non-emergent additional terminal care facility visits to a hospitalized patient by the attending or replacement physician during one day are to be billed under fee item 00127. The claim must include the time of each visit and a statement of need included in a note record.*

vi) *For weekday daytime emergency visit, see fee item 00112. Fee items 12200, 13200, P15200, 16200, 17200, 18200 may be billed for additional evening, night time, or weekend emergent terminal care facility visits same day, same patient when the attending physician or replacement physician is specially called back as the patient's condition has changed, requiring the physician's attendance or due to a condition unrelated to the hospitalization. If physician is on-site and called for emergent care, fee items 00113, 00105 or 00123 are billable. The claim must include the time of service and an explanation for the visit included in the note record.*

Community-based GP Hospital Visits
The following eligibility rules apply to all community based GP hospital visit fees.

Physician Eligibility:

- Payable only to the GP or practice group that accepts the role of being Most Responsible Physician (MRP) for the longitudinal coordinated care of his/her/their patient.
- Not payable to physicians who have been paid for any specialty consultation fee in the previous 12 months.
- Not payable to physicians who are employed by, or who are under contract, whose duties would otherwise include provision of this care.
- Not payable to physicians working under salary, service contract or sessional arrangements and whose duties would otherwise include provision of this care.

Community-based GP with Active Hospital Privileges
Active privileges signify the physician has the authority to write orders, whereas courtesy/associate privileges permit the GP to write progress notes in charts, but not orders.

13108 Community based GP: first routine hospital visit of the day (active hospital privileges) $73.34

Notes:

i) *Payable only for first hospital patient seen on any calendar day.*

ii) *Additional visits are not payable on same day to same physician for the same patient, except as set out in the notes iv) and v).*

iii) *Essential non-emergent additional visits to a hospitalized patient by the attending or replacement physician during one day are to be billed under fee item 00108 or 13008. The claim must include the time of each visit and a statement of need included in a note record.*

iv) *For weekday daytime emergency visit, see fee item 00112. Fee items 12200, 13200, P15200, 16200, 17200, 18200 may be billed for additional evening, night time, or weekend emergent hospital visits same day, same patient when the attending physician or replacement physician is specially called back as the patient's condition has changed, requiring the physician's attendance or due to a condition unrelated to the hospitalization. If physician is on-site and called for emergent care, fee items 00113, 00105 or 00123 are billable. The claim must include the time of service and an explanation for the visit included in the note record.*

v) *Only one visit is payable under 13108, 13127, or 13128 billable by same physician, same day, regardless of the number of facilities attended.*

13008 Community-based GP: hospital visit (active hospital privileges) $39.87

Notes:

i) Additional visits are not payable on same day to same physician for the same patient, except as set out in the notes ii) and iii).

ii) Essential non-emergent additional visits to a hospitalized patient by the attending or replacement physician during one day are to be billed under fee item 00108 or 13008. The claim must include the time of each visit and a statement of need included a note record.

iii) For weekday daytime emergency visit, see fee item 00112. Fee items 12200, 13200, P15200, 16200, 17200, 18200 may be billed for additional evening, night time, or weekend emergent hospital visits same day, same patient when the attending physician or replacement physician is specially called back as the patient's condition has changed, requiring the physician's attendance or due to a condition unrelated to the hospitalization. If physician is on-site and called for emergent care, fee items 00113, 00105 or 00123 are billable. The claim must include the time of service and an explanation for the visit included in the note record.

13128 Community-based GP: first supportive care hospital visit of the day (active hospital privileges) $62.10

Notes:

i) Payable only for first hospital patient seen on any calendar day.

ii) Referring physician may charge one supportive care hospital visit for each day hospitalized during the first ten days of hospitalization and thereafter one visit for every seven days hospitalized {Preamble B.4.e.v)}.

iii) Additional visits are not payable on same day to same physician for the same patient, except as set out in the following notes iv) and v).

iv) Essential non-emergent additional visits to a hospitalized patient by the physician providing supportive care for diagnosis unrelated to the admission diagnosis, during one day are to be billed under fee item 00108 and 13008. The claim must include the time of each visit and a statement of need included in a note record.

v) For weekday, daytime emergency visit, see fee item 00112. Fee items 12200, 13200, P15200, 16200, 17200, 18200 may be billed for additional evening, night time, or weekend emergent hospital visits same day, same patient when the attending physician or replacement physician is specially called back as the patient's condition has changed, requiring the physician's attendance or due to a condition unrelated to the hospitalization. If physician is on-site and called for emergent care, fee items 00113, 00105 or 00123 are billable. The claim must include the time of service and an explanation for the visit included in the note record.

vi) Only one visit is payable under 13108, 13127 or 13128 billable by same physician, same day, regardless of the number of facilities attended.

13028 Community-based GP: supportive care hospital visit (active hospital privileges) $33.75

Notes:

i) Referring physician may charge one hospital visit for each day hospitalized during the first ten days of hospitalization and thereafter one visit for every seven days hospitalized {Preamble B.4.e.v)}.

ii) Essential non-emergent additional visits to a hospitalized patient by the physician providing supportive care for diagnosis unrelated to the admission diagnosis, during one day are to be billed under fee item 00108 or 13008. The claim must include the time of each visit and a statement of need included in a note record.

iii) For weekday, daytime emergency visit, see fee item 00112. Fee items 12200, 13200, P15200, 16200, 17200, 18200 may be billed for additional evening, night time, or weekend emergent hospital visits same day, same patient when the attending physician or replacement physician is specially called back as the patient's condition has changed, requiring the physician's attendance or due to a condition unrelated to the hospitalization. If physician is on-site and called for emergent care, fee items 00113, 00105 or 00123 are billable. The claim must include the time of service and an explanation for the visit included in the note record.

T13148 Community-based GP: first sub-acute hospital visit of the day (active hospital privileges) $73.34

Notes:

i) Payable only for first patient seen for sub-acute care on any calendar day.

ii) Not payable on the same day to the same physician as 13108, 13114, 13127 or 13128 unless provided in a discrete facility which is in a separate geographic location from the acute care or extended care facility.

i) Additional visits are not payable on same day to same physician for the same patient, except as set out in notes iv) and v).

iv) Essential non-emergent additional visits to a patient receiving sub-acute care by the attending or replacement physician during one day are to be payable under fee item 12148. The claim must include the time of each visit and statement of need included in a note record.

v) For weekday, daytime emergency visit, see fee item 00112. Fee items 12200, 13200, P15200, 16200, 17200 or 18200 are payable for additional evening, night time, or weekend emergent sub-acute care facility visits same day, same patient when the attending physician or replacement physician is specially called back due to a change in the patient's condition which requires the physician's attendance or due to a condition unrelated to the hospitalization. If physician is on-site and called for emergent care, fee items 00113, 00105 or 00123 are billable. The claim must include time of service and explanation for the visit included in the note record.

13127 Community-based GP: first terminal care facility visit of the day (active hospital privileges) $73.34

Notes:

i) Payable only for first patient seen for palliative care on any calendar day.

ii) Not payable in addition to 00127, 00108, 00109, 13008, 13028, 13108, 00128, 13128, P13228, P13229, 12200, 13200, P15200, 16200, 17200, 18200, except as set out in notes vi) and vii).

iii) This item is applicable to the visits for palliative care rendered to terminally ill patients suffering from malignant disease or AIDS or end-stage respiratory, cardiac, liver and renal disease and end-stage dementia with life expectancy of up to 6 months and the focus of care is palliative rather than treatment aimed at cure. Billings for this item will only apply where there is no aggressive treatment of the underlying disease process and care is directed to maintaining the comfort of the patient until death occurs.

iv) This item may be billed for necessary visits rendered for a period not to exceed 180 days prior to death and is applicable to patients in an acute care hospital or nursing home, whether or not the patient is in a palliative care unit. Under extenuating circumstances, a note record must be submitted for visits that exceed 180 days.

v) The chemotherapy listings (33581, 33582, 33583, P00578, P00579 and P00580) may not be billed when terminal care facility visit fees are being billed.

vi) Essential non-emergent additional visits to a patient receiving palliative care by the attending or replacement physician during one day are to be payable under fee item 00127. The claim must include the time of each visit and statement of need included in a note record.

vii) *For weekday, daytime emergency visit, see fee item 00112. Fee items 12200, 13200, P15200, 16200, 17200, 18200 may be billed for additional emergent evening, night time, or weekend emergent terminal care facility visits same day, same patient when the attending physician or replacement physician is specially called back as the patient's condition has changed, requiring the physician's attendance or due to a condition unrelated to the hospitalization. If physician is on-site and called for emergent care, fee items 00113, 00105 or 00123 are billable. The claim must include time of service and an explanation for the visit included in the note record.*

viii) *Only one visit is payable under 13108, 13127 or 13128 billable by same physician, same day, regardless of the number of facilities attended.*

Community-based GP with Courtesy or Associate Hospital Privileges

P13229 Community-based GP: first hospital visit of the day (courtesy/associate privileges) $55.94

Notes:

i) *Payable only for first in-hospital patient seen on any calendar day.*

ii) *Payable once per calendar week per patient up to the first four weeks. Thereafter, this item is payable once per two weeks up to a maximum of 90 days. For visits over 90 days please submit note record.*

iii) *Payable for patients in acute, sub-acute care or palliative care.*

iv) *Not payable with G14015 or any other visit fee including P13228, 00108, 13008, 13108, 00109, 13114, 00114, 00115, 00113, 00105, 00123, 00127, 13127, 12200, 13200, P15200, 16200, 17200, 18200, 12201, 13201, P15201, 16201, 17201, 18201, T12148, T13148, 00128, 13028, 13128, 13015, 12220, 13220, P15220, 16220, 17220, 18220, 00121, 00122, 12210, 13210, P15210, 16210, 17210, 18210, 00116, 00112, 00111.*

v) *If physician is on-site and called for emergent care, fee items 00113, 00105 or 00123 are billable.*

vi) *A written record of the visit must appear in either patient's hospital or office chart.*

vii) *If a hospitalist is providing GP care to the patient, the community-based GP with courtesy or associate hospital privileges may bill P13228 or P13229 (if first visit of day).*

P13228 Community-based GP: hospital visit (courtesy/associate privileges) $27.97

Notes:

i) *Payable once per calendar week per patient up to the first four weeks. Thereafter, payable once per two weeks up to a maximum of 90 days. For visits over 90 days please submit note record.*

ii) *Payable for patients in acute, sub-acute care or palliative care.*

iii) *Not payable with G14015 or any other visit fee including P13229, 00108, 13008, 13108, 00109, 13114, 00114, 00115, 00113, 00105, 00123, 00127, 13127, 12200, 13200, P15200, 16200, 17200, 18200, 12201, 13201, P15201, 16201, 17201, 18201, T12148, T13148, 00128, 13028, 13128, 13015, 12220, 13220, P15220, 16220, 17220, 18220, 00121, 00122, 12210, 13210, P15210, 16210, 17210, 18210, 00116, 00112, 00111.*

iv) *If physician is on-site and called for emergent care, fee items 00113, 00105 or 00123 are billable.*

v) *A written record of the visit must appear in either patient's hospital or office chart.*

vi) *If a hospitalist is providing GP care to the patient, the community-based GP with courtesy or associate hospital privileges may bill P13228 or P13229 (if first visit of day).*

On-call On-site Hospital Visits

These listings should be used when a physician, located in the hospital or Emergency Department, is called to see a patient in either the Emergency Department or elsewhere in the hospital.

00113 Evening (between 1800 hrs. and 2300 hrs.) $48.25

00105 Night (between 2300 hrs. and 0800 hrs.) $67.87

00123 Saturday, Sunday or Statutory Holiday $48.25

Note: *For services rendered between 0800 hrs. and 1800 hrs. weekdays bill appropriate visit or procedure fee. Out-of-office hours premiums are not chargeable in addition to emergency department fees. Claim must state time call placed.*

Long-Term Care Facility Visits

00114 One or multiple patients, per patient $31.89

13114 Long-term care institution visit – first visit of the day $63.78

Notes:

i) Payable only for first patient seen on any calendar day regardless of number of long term care institutions attended.

ii) Not payable in addition to 00114.

iii) See Preamble clause B.4.e.vii) for long-stay patients.

iv) This fee is payable only for community based GPs.

00115 Nursing home visit – one patient, when patient seen between hours of 0800 hrs and 2300 hrs – any day $107.87

{See Preamble Clause B.4.e.vii), for long-stay patients}.

Emergency Visits

00112 Emergency visit (call placed between hours of 0800 and 1800 hrs.) – weekdays $107.87

Notes:

i) This item to be charged only when one must immediately leave home, office, or hospital to render immediate care. Call to hospital emergency department while at hospital, bill under appropriate on-call on-site hospital visit listings or procedure.

ii) Claim must state time service rendered.

The following are examples of situations explaining when it would be appropriate to bill under fee item 00112:

Example 1: Physician is called by patient with non-urgent condition. Physician agrees to meet the patient later in the day at the hospital. Fee item 00112 is not applicable, as the physician was not required to immediately leave home, office or hospital to render immediate care.

Example 2: Physician is called to assess a patient at the hospital. Due to the urgent nature of the patient's condition, the physician must leave his/her office immediately. Fee item 00112 is applicable, as all the criteria are met.

Example 3: Physician is visiting patients at the hospital during the daytime. She/he is called to attend a patient in the emergency ward. Due to the urgent nature of the patient's condition, the physician must attend the patient immediately. Fee item 00112 is not applicable, as the physician remained at the same site.

Example 4: The physician is called at home regarding a patient. She/he asks the patient to meet him/her at the office later in the day for assessment.

Fee item 00112 is not applicable, as the physician was not required to immediately leave home, office or hospital to render immediate care.

00111 An emergency home (or scene of accident) visit for an acutely ill or injured patient immediately followed by a trip to hospital to arrange for emergency admission and to include immediate associated hospital visit $109.82

OPHTHALMOLOGY

Amendments:

Effective July 1, 2009, the cancellation dates of the following provisional items have been extended. This Minute will expire on December 31, 2010 or when replaced by a subsequent Minute, whichever occurs first.

P22067 Computerized retinal nerve fibre layer photography and neuro-retinal assessment (e.g.: Heidelberg, GDX) $63.92
P22068 - professional fee $12.28
P22069 - technical fee $51.64

Effective Mary 27, 2009, the following note is added to the indicated fee items:

P22067 Computerized retinal nerve fibre layer photography and neuro-retinal assessment (e.g.: Heidelberg, GDX)
P22068 - professional fee
P22069 - technical fee

Notes:

iv) includes 02007, 02018, 02019.

CARDIOLOGY

Amendments:

Effective April 1, 2009 the following fee item has been approved on a provisional basis. This Minute will expire on September 30, 2010, or when replaced by a subsequent Minute, whichever occurs first:
Also, the following anesthetic intensity and complexity levels are added to the indicated fee item as follows:

PC33076 Percutaneous balloon valvuloplasty for aortic stenosis (composite fee) ..... $600.00 **Anes Level** 9

Notes:

i) Includes all necessary catheterizations, angiography (00801, 00810, 00812, 00827, 00871, 00888, 00889, 33030), angiocardiography, intra-arterial cannulation, right heart catheterization, retrograde left heart catheterization, pulse tracing (intravascular), temporary pacemaker, any medically necessary diagnostic imaging (e.g.: Intra-cardiac ultrasound), CVP, arterial lines, blood pressure measurements, and any pharmacological infusion and studies, blood sampling, blood analysis and interpretations done in association with procedure.

ii) Pre and 48 hour post-operative visits in hospital included.

iii) 00840 (percutaneous trans-luminal coronary angioplasty) and 00841 (direct coronary angiography) may be billed at 50 per cent if done with this Procedure

iv) If a Cardiology assist is required, may bill Cardiology Assist Fee Items 00845 (first hour or fraction thereof) and 00846 (after one hour, each 15 minutes or fraction thereof) at 50 per cent.

Effective April 1, 2009, the following fee item has been approved on a provisional basis. This Minute will expire on September 30, 2010, or when replaced by a subsequent Minute, whichever occurs first:
Also, the following anesthetic intensity and complexity levels are added to the indicated fee item as follows:

PS33075 Percutaneous balloon valvuloplasty for congenital or rheumatic mitral stenosis (composite fee).....$900.00 9

Notes:

i) Includes all necessary catheterizations, angiography (00810, 00812, 00827, 00830, 00871, 00888, 00889 and 00898), angiocardiography, atrial septostomy, balloon dilation of atrial septum, any medically necessary diagnostic imaging, CVP, arterial lines, blood pressure measurements, and any pharmacological infusion and studies, blood sampling, blood analysis and interpretations done in association with procedure.

ii) Pre and 48 hour post-operative visits in hospital included.

Effective April 1, 2009, the following note is added to the indicated fee item:

P33093 Level III Echocardiographer Complex Assessment of Previous Echocardiogram (clinical assessment and review, interpretation and written report of submitted echocardiograms) – per patient..... $125.31

Notes:

vii) Not payable in addition to a consultation rendered within 2 months on the same patient on referral by the same physician for the same diagnosis.

GERIATRIC MEDICINE

Amendments:

Effective April 1, 2009, the following fee item description is amended as indicated:

P33421 Telehealth Comprehensive geriatric consultation - limited to patients aged **65** years and over: To consist of examination, review of history, laboratory, X-ray findings, and additional visits necessary to render a written report which reflects the necessary components and complexity of care

The following Geriatric Medicine Preamble is amended as indicated; the addition is in bold font:

Criteria for Billing Fee items 33401, 33402, P33421, P33422:

3. Applicable only when written report includes at least two aspects of complexity. Common clinical syndromes include, but are not limited to the following:
    - Assessment and management of medical condition(s)/syndrome(s) in those 75 yrs and over (except 33401 **and P33421** which applies to patients 65 yrs and over)

ORTHOPAEDICS

Amendments:

Effective April 1, 2009, the following anesthetic intensity and complexity levels are added to the indicated fee item as follows:

53644 Osteocapsular arthroplasty (elbow, open or arthroscopic).....$900.00 4

PEDIATRICS

Amendments:

Effective October 1, 2009, the cancellation dates of the following provisional items have been extended. This Minute will expire on September 30, 2010 or when replaced by a subsequent Minute, whichever occurs first:

P00550 Extended Consultation – exceeding 53 minutes (actual time spent with patient): To consist of an examination, review of history, laboratory, x-ray findings, and additional visits necessary to render a written report

P00551 Extended Consultation – exceeding 68 minutes (actual time spent with patient): To consist of an examination, review of history, laboratory, x-ray findings, and additional visits necessary to render a written report

P00553 Extended subsequent office visit – exceeding 23 minutes (actual time spent with patient):

P00554 Extended subsequent office visit – exceeding 38 minutes (actual time spent with patient):

PSY00541 Pediatric urethral catheterization in child under 5 years – isolated procedure

Chemotherapy

a) *Where a patient has been administered high intensity cancer chemotherapy, the fees for limited cancer chemotherapy are not payable within the interim of 28 days.*
b) *Hospital visits are not payable on the same day.*
c) *Visit fees are payable on subsequent days, when rendered.*
d) *A consultation, when rendered, is payable in addition to fee item P00578, high intensity cancer chemotherapy, in situations where it is important that chemotherapy be administered immediately, e.g.: for out of town patients. A letter of explanation is required when both services are performed on the same day.*
e) *The administering of chemotherapy via intrathecal and intrabladder methods is payable under the chemotherapy listings. Other methods of administration, such as oral and rectal, are not payable under these listings.*

P00578 High Intensity Cancer Chemotherapy for patients 16 years of age and under:
To include admission history and physical examination, review of pertinent laboratory and radiological data, counselling of patient and/or family, venesection and institution of an intravenous line, and administration of a parenteral chemotherapeutic program which must be given on an in-patient basis

P00579 Major Intensity Cancer Chemotherapy for patients 16 years of age and under:
To include history and physical examination as necessary to document disease status, review of pertinent laboratory and radiological data, counselling of patient and/or family, venesection and institution of an intravenous line and administration of multiple parenteral chemotherapeutic agents

P00580 Limited Intensity Cancer Chemotherapy for patients 16 years of age and under:
To include the administration of single parenteral chemotherapeutic agents, history and physical examination as necessary to document disease status, counselling of patient and/or family, review of pertinent laboratory and radiologic data, venesection and institution of an intravenous line

PSY00570 Lumbar puncture in a patient 12 years of age and younger

PS00571 Pediatric esophagogastroduodenoscopy in a patient 16 years of age and under

PS00572 Pediatric colonoscopy with flexible colonoscope – patients 16 years of age and under

PS50520 Pediatric right heart catheterization – patients 0 – 6 years of age

PS50521 Pediatric right heart catheterization – patients 7 – 16 years of age

PS50527 Pediatric retrograde left heart catheterization, extra – patients 0 – 6 years of age

PS50528 Pediatric retrograde left heart catheterization, extra – patients 7 – 16 years of age

PS50530 Pediatric trans-septal left heart catheterization – patients 0 – 6 years of age

PS50531 Pediatric trans-septal left heart catheterization – patients 7 – 16 years of age

PS50539 Pediatric percutaneous transluminal coronary angioplasty – patients 0- 6 years of age

PS50540 Pediatric percutaneous transluminal coronary angioplasty – patients 7- 16 years of age

PS50541 Pediatric direct coronary angiography (catheterization of coronary ostia) – patients 0 – 6 years of age

PS50542 Pediatric direct coronary angiography (catheterization of coronary ostia) – patients 7– 16 years of age

PS50545 Pediatric therapeutic radiological embolization – patients 0 – 6 years of age
PS50546 Pediatric therapeutic radiological embolization – patients 7 – 16 years of age

P50550 Percutaneous cardiac stenting in pediatric patients (0 – 18 years of age) - composite fee (operation only)

P50551 - Additional stents – extra

P50555 Percutaneous transcatheter cardiac occluder device closure of ASD in pediatric patients (0 – 18 years of age) – composite fee (operation only)

Effective October 1, 2009, the cancellation date of the following provisional item has been extended. This Minute will expire on September 30, 2010 or when replaced by a subsequent Minute, whichever occurs first:

P00545 Pediatric Case Conference – a formal, scheduled session/meeting, initiated at the request of the pediatrician, to discuss/plan medical management of patients with serious and complex pediatric problems, which may include family physicians or hospital staff (if an in-patient) or a relative and must include at least one professional or community agency representative.
– per ¼ hour $45.39

GENERAL SURGERY

Amendments:

Effective October 1, 2009, the cancellation dates of the following provisional items have been extended. This Minute will expire on September 30, 2010, or when replaced by a subsequent Minute, whichever occurs first:

P71623 Laparoscopic initial ventral or incisional hernia repair, reducible or strangulated, with mesh, with or without enterolysis. $565.13 5

P71624 Laparoscopic recurrent ventral or incisional hernia repair, reducible or strangulated, with mesh, with or without enterolysis. $719.26 6

VASCULAR SURGERY

Amendments:

Effective May 28, 2009, the note appended to the indicated fee item is amended as follows in bold:

77385 Removal by dissection of chronic peritoneal catheter - operation only $127.79 3
Note: *For removal of* ***Tenckhoff*** *type chronic peritoneal catheter not requiring surgical dissection, use visit fees.*

DIAGNOSTIC RADIOLOGY

Amendments:

Effective August 7, 2009, the provisional status ("P") of the following items is removed:

10901 Percutaneous image-guided catheter directed thrombolysis of peripheral vein/artery 556.09 2

10902 Peripherally inserted image-guided central venous catheter line (PICC) 105.92 2

10903 Percutaneous hemodialysis graft thrombolysis 556.09 2

LABORATORY MEDICINE

New Fee Items:

Effective May 1, 2009, the following new fee item has been approved on a provisional basis. This Minute will expire on October 31, 2010 or when replaced by a subsequent Minute, whichever occurs first. The following new listing is to be added under the heading "Chemistry":

P91858*** Interferon beta, neutralizing antibodies $203.66

Notes:

i) Performance of this test is limited to the UBC Neuroimmunology Laboratory.

ii) Payable only when ordered by Neurologists at the Multiple Sclerosis (MS) Clinics in B.C.

iii) Paid only for multiple sclerosis patients at MS Clinics receiving Interferon beta.

iv) Testing frequency for a MS patient may be every three months in specific clearly documented circumstances.

Amendments:

Effective March 1, 2009, Note ii) a) appended to the indicated fee item is amended as follows in bold and underlined:

P90046*** Beta 2 Glycoprotein I (B2GPI) antibody screen $40.03

Notes: *The following indications for this test include:*

i) Patients with vascular thrombosis – one or more clinical episodes of arterial, venous or small vessel thrombosis in any tissue or organ. Thrombosis must be confirmed by objective validated criteria.

ii) Patients with pregnancy morbidity:

a) One or more unexplained deaths of a morphologically normal fetus at or beyond the 10th week of gestation, with normal fetal morphology documented by ultrasound or by direct examination of the fetus.

b) One or more premature births of a morphologically normal neonate before the 34th week of gestation because of: eclampsia or severe pre-eclampsia defined according to standard definitions or recognized features of placental insufficiency, or

c) Three or more unexplained consecutive spontaneous abortions before the 10th week of gestation, with maternal anatomic or hormonal abnormalities, and paternal and maternal chromosome causes excluded.

Effective July 1, 2009, the cancellation date of the following provisional item has been extended. This Minute will expire on April 30, 2010 or when replaced by a subsequent Minute, whichever occurs first:

P90784 Trichomonas Antigen Test $18.58

Effective May 1, 2009, the payment rate of the indicated item is increased as follows:

P91925*** Light Chains, free kappa and lambda with ratio - quantitative $46.26

Effective August 1, 2009, the spelling of "Helicobacter" is clarified and the cancellation date of the following provisional item has been extended. This Minute will expire on July 31, 2010 or when replaced by a subsequent Minute, whichever occurs first:

P91761 Helicobacter pylori stool antigen (HPSA)

Effective September 14, 2009, the provisional status ("P") of the following items is removed:

92355 Troponin.....$14.92

92227 Sirolimus.....$42.62

92513 Methadone.....$3.47